



BEVERLY HILLS Rejuvenation Center

RESTORING HEALTH AND VITALITY

Name: _____

Date of Birth: _____ Age: _____ Male Female

Address: _____

City: _____ State _____ Zip Code _____

Home Ph: _____ Mobile Ph: _____ Work Ph: _____

Confidential E-Mail (to send you confidential medical information): _____

Confidential Fax (to send you confidential medical information): _____

Blood Type _____ Frame Size: Small Medium Large

Personal Physician name and phone number: _____

Do you have health insurance? _____ What kind of insurance (ex: HMO, PPO ?) _____

What is your current occupation? _____

Marital Status: Single Married Divorced Widowed

Who lives in your household ? _____ How many children do you have? _____

Height: _____ Weight _____ Lowest Adult Weight: _____ Highest Adult Weight: _____

How would you describe your current health: Poor Average Good Excellent

What are your Health Goals? _____

How are you wanting Beverly Hills Rejuvenation Center to help you accomplish your goals:

your health goals? _____

How did you hear about Beverly Hills Rejuvenation Center?

A. Medical History

Please check the column if you have any of these conditions. If any of your siblings/relatives have had a history of any of these conditions, please list what relation they are to you in the sibling/relative column.

Is there a history of:

Condition	Myself	Sibling/Relative
Weight Control Problems		
Diabetes		
Arthritis		
Heart Disease		
Autoimmune Disease (<i>lupus, rheumatoid arthritis, etc</i>)		
Cancer		
High Blood Pressure		
Bladder disease		
Liver Disease (<i>hepatitis, cirrhosis, etc</i>)		
Kidney Disease (<i>stones, infections, cysts, etc.</i>)		
Neurological Disorders (<i>stroke, seizures, Parkinson's etc</i>)		
Psychiatric Illness (<i>depression, anxiety, psychotic disorders</i>)		
Lung Disease (<i>asthma, emphysema, bronchitis, etc</i>)		
Substance Abuse (<i>alcohol, prescription, or recreational drugs</i>)		
Bowel Disease (<i>malabsorption, lactose intolerance, Crohn's etc</i>)		
Endocrine Gland Disorders (<i>thyroid, adrenal, pituitary</i>)		
Stomach/Esophagus Disorders (<i>reflux, stricture, ulcers, etc.</i>)		
Osteoporosis		
Allergies		
Anemia		
Migraine Headaches		
HIV/AIDS		
Memory Problems		
Sleep Apnea/Snoring		

Please give details for any of the conditions you checked "Yes" including dates, treatment and last time treated:

Please list any/all surgical procedures you've had and the date of the procedure:

Have you ever had a transfusion? If yes, please list the date and reason:

Do you participate in any recreational drug use? If yes, please list what and how often.

Do you have any drug allergies? If yes, to what?

Please describe the reaction _____

Do you have seasonal allergies? If yes, please describe

Do you have food allergies? If yes, to what?

Please describe the reaction _____

Do you have an allergy to latex? If Yes, please describe reaction

For the following categories, please check any symptoms you are currently having.

Eyes, Ears, Nose and Throat Symptoms					
	YES	NO		YES	NO
Hearing loss			Double vision		
Balance problems			Nosebleeds		
Sinus infections			Sore or bleeding gums		
Ear pain			Stuffy nose		
Ringing in ears			Blurred or tunnel vision		
Change in vision			Sore throat		
Ear drainage			Canker or cold sores		

Cardiopulmonary Symptoms					
	YES	NO		YES	NO
Cannot tolerate even small amounts of exercise			Heaviness in legs		
Chronic lung congestion			Exhaustion with little exertion		
Rapid heartbeat			Recurring upper respiratory infections		
Erratic blood pressure			Cramps in calves while walking		
Nighttime breathing problems			Heart misses beats		
Pain in left side — describe where			Fluid retention		
Pain in right side-- describe where			Shortness of breath		
Difficulty breathing			Heartburn after eating		
Pain in left arm			High blood pressure		
Wheezing			Low blood pressure		
Heart pounds easily			Difficulty lying flat		
Chest pain when walking					

Kidney, Bowels, Bladder and Gastrointestinal					
	YES	NO		YES	NO
Abdominal pain			Frequent urinary tract infections		
Blood in urine			Difficulty urinating		
Blood in stool			Gallbladder problems		
Hemorrhoids			Heartburn/reflux		
Frequent urination			Nausea or vomiting		
Frequent nighttime urination			Diarrhea		
Loss of bladder control			Difficulty swallowing		
Kidney stones			Constipation		
Burning during urination			Dependency on Antacids		
Loss of bowel control					

Neurological Symptoms					
	YES	NO		YES	NO
Difficulty Walking			Paralysis		
Tremors			Loss of smell or taste		
Dizziness			Tingling or numbness		
Muscle weakness			Memory problems		
Headaches			Uncoordinated		
Faintness			Difficulty talking		
Balance problems			Difficulty with attention and concentration		
Seizures/convulsions					

Metabolic Symptoms					
	YES	NO		YES	NO
Feel faint or weak			Night sweats		
Cold hands or feet			Crave sweets		
Crave salt			Weight gain of more than 10lbs		
Weakness when missed a meal			Weight loss of more than 10lbs.		
Increase thirsts			Crave sweets in the middle of the night		
Thinning or loss of outside portion of eyebrow			Certain food make you ill		
Body temperature below 97.6F			HDL cholesterol below 50		
Need to drink caffeine to get going			LDL cholesterol above 130		
Sugar in urine			Total cholesterol above 200		
Feel tired 1 to 3 hours after eating			Difficulty gaining weight		
Gain weight easily			Difficulty losing weight		
Blushing with no cause			Swollen eyes		
Overweight			Very sensitive to the cold		
Weight has stayed consistent over last five years			Bad breath		
Irritable if miss a meal			Body odor		

Joint, Muscle and Bones Symptoms					
	YES	NO		YES	NO
Arthritis			Limited motion		
Fibromyalgia			Back Pain		
Joint pain, swelling or stiffness			Muscle tension or spasms		
Carpal Tunnel Syndrome					

Mind and Emotions Symptoms					
	YES	NO		YES	NO
Short attention span			Problems with memory		
Depression			Trouble concentrating		
Rapid mood swings			Confusion		
Lack of self-esteem			Trouble comprehending		
Sleep disturbances			Excessive worry		
Lack of mental alertness			Difficulty making decisions		
Short temper/anger			Frequent infections		
Irritable			Excessive stress		
Personality changes			Suicidal thoughts		
Anxiety/fear			Weakness, fatigue		
Impatient, nervous			Restlessness, hyperactivity		

Skin and Hair Symptoms					
	YES	NO		YES	NO
Age spots			Flushed face, hot flashes		
Puffy, wrinkled skin			Thick skin and fingernails		
Thinning hair, losing hair			Persistent rash/skin allergy		
Acne			Slow or poor wound healing		
Dry hair			Bruise easily or excessively		
Dry skin			Sores, boils, or sties		
Dark circles under eyes			Nail fungus		
Bumpy skin on face or backs of arms			Excessive sweating		
Hives			Spider veins in nose or on face		

Miscellaneous Symptoms					
	YES	NO		YES	NO
Fatigue			Broken bone as adult		
Insomnia			Sleep too much		
Change in appetite			Sleep apnea		
Lumps in neck, armpits, groin or breast			Other		

Womens' Health Questionnaire

Date of last menstrual period: _____ What form of birth control do you use? _____

Have you had a hysterectomy? If yes, why and when?

Date of last pap smear/pelvic exam: _____ Date of last rectal exam: _____

Date of last breast exam: _____ Date of last stress EKG: _____

Date of last mammogram: _____ Date of last chest X-ray: _____

Date of last colonoscopy: _____ Date of last eye exam: _____

Symptoms					
	YES	NO		YES	NO
Water retention			History of ovarian cysts		
Tender breasts			History of uterine cysts/fibroids		
Craving for sweets			Premenstrual Syndrome		
History of Endometriosis			Missed periods		
Low Backache			Menstrual pain		
Vaginal itching			Irregular periods		
Vaginal discharge			Pelvic or vaginal soreness and or pain		
Vaginal sores			Heavy menstrual bleeding		
Vaginal dryness			Overactive sex drive		
Pain in ovaries			Bloating or swelling		
Dislike of intercourse			Infertility		
History of miscarriages			Monthly weight gain		
Past or present sexually transmitted disease			Hot flashes/night sweats		
Pain in ovaries			Underactive sex drive		
Sweating throughout the day					

Mens' Health Questionnaire

Date of last prostate exam: _____ Date of last chest X-ray: _____

Date of last PSA: _____ Date of last EKG: _____

Date of last rectal exam: _____ Date of last eye exam: _____

Date of last colonoscopy: _____

Symptoms					
	YES	NO		YES	NO
Infertility			Difficulty attaining an erection		
Painful ejaculation			Difficulty maintaining an erection		
Discharge from penis			Low sperm count		
Overactive sex drive			Past or present rash on penis		
Underactive sex drive			Jock itch		
Varicose veins on scrotum			Swollen genitals		
Premature ejaculation			Swollen groin		
Pain in genital area			Genital sores		
Coldness in genital area					

Medication Usage					
	YES	NO		YES	NO
Do you use Viagra?			Has it helped?		
If yes, how often?			Do you use Viagra?		

Do you use any other medication for sexual function? If yes, please list below, describe the results?

Lifestyle

On a scale of 1-10, 10 being the highest, rate the level of stress in your life. _____ Please explain:

What hobbies do you participate in?

Do you smoke? If yes, what do you smoke? _____ How much per day? _____

If quit, when? _____

Do you or have you used any other types of tobacco? If yes, please explain

How many alcoholic beverages do you consume per wk? _____

How often do you exercise per week (including cardio, weight/strength training, biking, swimming, yoga, tai chi, stretch and toning classes)?

What type of exercise?

How long do you exercise?

Describe your exercise routine:

Fitness Assessment

Question	YES	NO
Are you currently involved in an exercise program?		
If yes, how long?		
Do you belong to a gym?		
Have you ever belonged to a gym?		
Have you ever worked with a personal trainer?		
Are you still with a trainer?		
Are you receiving physical therapy?		
Do you have exercise equipment at home? If yes please explain:		

Your Diet

How many cups of coffee do you drink a day? _____

How many diet sodas or other drinks with aspartame do you drink a day? _____

How many cups of tea do you drink a day? _____

How much water do you drink a day? _____

How many high sugar foods do you eat a day? Please explain

Are you a vegetarian? _____

If yes, what type? Lacto (plant and dairy), Fruitarian (fruits, nuts, honey, and vegetables only), Vegan (plant products only), Ovo-lacto-vegetarian (plant, dairy, and egg products)

Holmes-Rahe Life Changes Scale

Event	Number of times occurred in past year
Death of a close family member	
Foreclosure of mortgage or loan	
Personal injury or illness	
Gain of a new family member	
Mortgage over \$100,000	
Marriage	
Pregnancy	
Trouble with in-laws	
Marital reconciliation	
Change in health of a family member	
Death of a close friend	
Began or ended school	
Revision of personal habits	
Change in residence	
Change in recreation	
Change in eating habits	
Vacations	
Retirement	
Spouse began or stopped work	
Trouble with boss	
Change in religious activities	
Change in number of family get-togethers	
Religious holidays	
Sexual difficulties	
Death of spouse	
Marital separation	
Business readjustment	
Change to a different line of work	
Change in responsibilities at work	
Change in social activities	
Minor law violations	
Change in financial state	
Divorce	
Change in number of arguments with spouse	
Son or daughter leaving home	
Change in sleeping habits	
Change in work hours or conditions	
Jail term	
Outstanding personal achievement	
Change in schools	