VITALITY CENTERS NW
Spokane Vitality Center
Vitality Men's Center

Patient Information Form

*** Please answer all questions ***

I am a (check one): _____ New / _____ Existing Patient

PERSONAL INFORMATION

Full Legal Name: _____
LAST FIRST MIDDLE

Mailing Address: _____
NUMBER STREET UNIT

_____
CITY STATE ZIP

Phone: (_____) _____ Email: _____

Date of Birth: _____ Age: _____

Marital Status (check one): _____ Married; _____ Divorced; _____ In a committed relationship; _____ Single

Age of all children in home: _____

Gender (check one): _____ Male _____ Female Height: _____ Weight: _____

Occupation: _____ Employer: _____

Primary physician or clinic: _____ Date of last physical exam: _____

PAST MEDICAL HISTORY

Please indicate if you have, or have ever had, one of the following:

Currently Have	Previously Had		Currently Have	Previously Had	
_____	_____	Anemia	_____	_____	Hepatitis
_____	_____	Arthritis	_____	_____	Heart Disease
_____	_____	Asthma	_____	_____	High Blood Pressure
_____	_____	Blood Disease	_____	_____	High Cholesterol
_____	_____	Bronchitis	_____	_____	Kidney Disease
_____	_____	Diabetes	_____	_____	Migraines
_____	_____	Emphysema	_____	_____	Mononucleosis
_____	_____	Epilepsy	_____	_____	Pneumonia
_____	_____	Gout	_____	_____	Psychological Problems

Currently Have	Previously Had	
_____	_____	Rheumatic Fever
_____	_____	Seizures
_____	_____	Stroke
_____	_____	Thyroid Disease
_____	_____	TB
_____	_____	Ulcers

Currently Have	Previously Had	
_____	_____	Urinary Tract Infections

Have you ever had any form of cancer? If so, please detail: _____

_____

_____

Known Allergies (list all and severity): _____

_____

_____

Current Medications (list all, including dose): _____

_____

_____

Current Nutritional Supplements (list all, including dose): _____

_____

_____

Do you smoke? _____ No; _____ Yes - If yes, how much? _____ How long? _____

Do you consume alcohol? _____ No; _____ Yes - If yes, how much? _____

Do you use illegal drugs? _____ No; _____ Yes - If yes, what and how much? _____

Past Surgical History

Please list any past surgeries, including but not limited to: Appendectomy; Cholecystectomy (gall bladder removal); Mastectomy (removal of breast material – including for gynocomastia); Tonsillectomy; Prostatectomy; Hernia repair; Other surgeries (please explain):

TYPE OF SURGERY	DATE	OUTCOME
TYPE OF SURGERY	DATE	OUTCOME
TYPE OF SURGERY	DATE	OUTCOME
TYPE OF SURGERY	DATE	OUTCOME

Have you ever been hospitalized (other than the previous mentioned surgeries? If so, please list the reason and give approximate date(s):

REASON	DATE	OUTCOME
REASON	DATE	OUTCOME
REASON	DATE	OUTCOME

FAMILY MEDICAL HISTORY

Have your siblings, parents or grandparents ever had the following (please indicate relationship)?

- ☐ Heart attack _____
- ☐ Diabetes _____
- ☐ Kidney Disease _____
- ☐ Leukemia _____
- ☐ Mental disorders _____
- ☐ Stroke _____
- ☐ Prostate cancer _____
- ☐ Other cancer _____

REVIEW OF SYSTEMS

Do you CURRENTLY have any of the following?

- ☐ Headaches
- ☐ Vision changes
- ☐ Hearing changes
- ☐ Chronic sinusitis
- ☐ Allergic sinus problems
- ☐ Tenderness/Sores in mouth/throat
- ☐ Bloody noses
- ☐ Chronic cough
- ☐ Spit up blood
- ☐ Shortness of breathe
- ☐ Chest pain
- ☐ Dizziness
- ☐ Congestive heart failure
- ☐ Palpitations
- ☐ Any form of arrhythmia
- ☐ Heart murmur
- ☐ Recurring constipation
- ☐ Recurring diarrhea
- ☐ Gallbladder disease
- ☐ Throw up blood
- ☐ Blood in stool or black, tarry stool
- ☐ Hernia
- ☐ Loss of appetite
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Jaundice (yellow skin)
- ☐ Yellow looking eyes
- ☐ Abdominal pain, If yes, explain: _____
- ☐ Pancreatitis
- ☐ Problems with urination (i.e. pain, blood, etc.)
- ☐ History of STD (sexually transmitted disease)
  If yes, type _____
- ☐ Tingling in fingers or toes

REVIEW OF SYSTEMS, Hormone Specific

Do you CURRENTLY have any of the following?

- ☐ Acne; If yes, please describe (include age and severity) _____
- ☐ Problems with passing out
- ☐ Cold intolerance
- ☐ Bruise easily
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Generalized muscle aches/pains
- ☐ Joint pain
- ☐ Back pain
- ☐ Fatigue
- ☐ Lethargy

Do you consider yourself to be in good health? _____ Yes _____ No

Do you sleep well? _____ Yes _____ No

Average hours of sleep per night _____

MALE PATIENTS ONLY

Do you CURRENTLY have any of the following:

- ☐ Decreased sexual potency; If so, is this causing stress in your relationship: ____ Yes ____ No
- ☐ Nocturnal emissions
- ☐ Sensitive or swollen nipples
- ☐ Loss of appetite
- ☐ Unexplained weight loss or gain
- ☐ Plan on having more children
- ☐ Decrease in strength or endurance
- ☐ Enjoying life less
- ☐ Sad or grumpy
- ☐ Erections less strong
- ☐ Decreased work performance
- ☐ Hard time recovering from physical activity

Do you regularly perform testicular self-exams? _____ Yes _____ No

Have you ever taken/currently taking, any type of hormone (i.e. testosterone) _____ Yes _____ No

If yes, please provide details (include age, type, reason, etc.) _____

_____

Please describe your diet: _____

_____

_____

I have completed the medical history form to the best of my knowledge.
I certify that my answers are honest and true.

Signed: _____

Date: _____