NEW PATIENT MEDICAL HISTORY FORM

Name: (First) ______________________________ (Last) ______________________________ (MI) ____

Age: ________________________

Address: ____

City/postal Code: ____

Country: ____

Phone: (Home)________________________ (mobile) ________________________

Email Address:____

1) How did you hear about us?

2) What is your main concern that you would like Dr Giannoulis to address?

3) To determine your current state of health, could you please tick as it applies to each condition or question.

Heart disease (angina, heart failure, heart attack, stroke): **yes** or **no**

Hypertension (high blood pressure): **yes** or **no**

Hyperlipidemia (high cholesterol): **yes** or **no**

Diabetes: **yes** or **no**

Neurological disorder (epilepsy, seizure, stroke): **yes** or **no**

Joint or mobility problems (arthritis or rheumatism): **yes** or **no**

Hormonal disorders (thyroid, adrenal, pituitary gland diseases) : **yes** or **no**

Kidney disorders: **yes** or **no**

Lung disorders (asthma, pneumonia, emphysema): **yes** or **no**

Peptic ulcer, liver or gall bladder disease: **yes** or **no**

Osteoporosis: **yes** or **no**

4) History of cancer... if yes, what type(s) of cancer, date(s), and treatment type(s)

5). Have you had any other medical problems that have been diagnosed by other healthcare professionals or any serious surgeries (describe):

6) Medications (list all current medications and dosages):

7) Allergies:

8). Do you have a history of drug or alcohol abuse (if yes please specify)

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9) Exercise type:
Duration: _____ hour’s _____ minutes   Number of times per week: _____
If not, what prevents you from exercising?

10) FAMILY HEALTH HISTORY

Do you have a first degree relative who has been diagnosed with cancer? **yes** **no**

If so, what type?

11) Could you please answer the following questions (ADAM –questionnaire).

Do you have a decrease in libido (sex drive)?	Yes No
Do you have a lack of energy?	Yes No
Do you have a decrease in strength and/or endurance?	Yes No
Have you lost height?	Yes No
Have you noticed a decreased "enjoyment of life"	Yes No
Are you sad and/or grumpy?	Yes No
Are your erections less strong?	Yes No
Have you noticed a recent deterioration in your ability to play sports?	Yes No
Are you falling asleep after dinner?	Yes No
Has there been a recent deterioration in your work performance?	Yes No