Hcg Protocol Questionnaire

(ALL INFORMATION CONTAINED IN THIS QUESTIONNAIRE IS STRICTLY CONFIDENTIAL, WILL BE PROTECTED TO THE HIGHEST OF HIPAA STANDARDS, AND WILL BECOME PART OF YOUR DFW ANTI-AGING AND WELLNESS CENTERS MEDICAL RECORD.)

Name (First, M.I., Last) _____

E-mail _____

Address (street) _____

(city) _____ (state) _____ (zip) _____

Phone (cell) _____ (work) _____

Date of birth_____ Gender: □ Male □ Female Occupation _____

Primary Care Physician (name) _____

Date of last physical with your physician _____ Results _____

LIFESTYLE	YES	NO	
Do you smoke?	□	□	If yes, how much per day _____
Do you drink alcohol?	□	□	If yes, how much per day _____
Do you drink caffeine?	□	□	If yes, how much per day _____
Do you exercise?	□	□	If yes, please describe _____

FAMILY HISTORY age; significant health issues

Father _____

Mother _____

Brothers/Sisters_____

PERSONAL MEDICAL HISTORY

Current medical conditions _____

_____

_____

_____

_____

Surgeries _____

_____

Current medications (Name, dosage, frequency)_____

_____

_____

Medication or food allergies, and reaction _____

_____

Current vitamins and supplements _____

_____

_____

Medical Review:

□Alcoholism	□Low energy	□Pneumonia
□Alopecia (hair loss)	□Headaches	□Prostate problems
□Anemia	□Heart disease	□Psoriasis
□Angina (chest pain)	□Hemorrhoids	□Rash (other)
□Anxiety/depression	□Hernia	□Reflux
□Arthritis	□Hepatitis (liver disease)	□Sinus problems
□Asthma	□High blood pressure	□Seizures (epilepsy)
□Back pain	□High cholesterol	□Sexual dysfunction
□Blood clots	□Joint pain	□Stroke
□Cancer	□Menstrual disorders	□Thyroid disorder
□Constipation	□Mental illness	□Tuberculosis
□Diabetes	□Muscle weakness	□Ulcers
□Diarrhea	□Migraines	□Urinary problems
□Diverticulitis	□Nausea	□UTIs
□Edema (swelling)	□Osteoporosis	□Varicose veins

Women only:

Number of children _____ □ Natural □ C-section
Last menstrual period _____/_____

Birth Control Pills □ Yes□ No
Rx_____

Hormone Replacement□ Yes□ No
Rx_____
Men only:
Date of last PSA _____ Results _____

Nutritional Evaluation:

Current weight:_____ Height: _____ Desired weight:_____

Birth weight: _____ Weight at age 20: _____Weight one year ago: _____

Previous diets, supplements, programs:

Method_____ Year_____ Weight Loss_____

Method _____Year_____ Weight Loss _____

Do you have certain food cravings? _____

Have you been challenged with or diagnosed with an eating disorder in the past? _____

Do you have food binges? _____ Do you eat in the middle of the night? _____

How much water do you drink daily? _____ diet soft drinks? _____

Regular soft drinks? _____ iced tea?_____ alcohol? _____

Do you use artificial sweeteners? _____ If so, which type? _____

Do you own a scale? _____ How often do you weigh yourself? _____

Do you have gastro-intestinal issues: □ reflux □ gas □ bloating □ unexplained diarrhea/constipation

Do you have sleep issues: □ insomnia □ sleep apnea □ CPAP □ early wakening

What is your most important reason for weight loss? _____

I certify that this is my true and accurate medical history. I have informed the physicians and staff of DFW Anti-Aging and Wellness Centers
of my complete physical and mental condition as well as all medications and supplements. I acknowledge and assume all responsibility for any condition(s) I have failed to disclose.

Signed: _____ Date: _____