Emmanuela Wolloch, MD
MALE HORMONE INTAKE

GENERAL INFORMATION: **Appointment Date**: _____

FIRST NAME: _____ **LAST NAME:** _____

Address: _____ **City** _____ **State** ____ **Zip** _____

Age: _____ **Birthdate:** _____ **Email:** _____

Home Phone: (_____) _____-_____ **Work /Cell Phone:** (_____)_____-_____

Occupation: _____ **Employer:** _____

Employment Status: ☐ Full-time ☐ Part-Time ☐ School ☐ Retired ☐ Unemployed
☐ Other_____

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents
Number of Children_____

Names and ages of those living with you: _____

_____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Partner/Spouse/Parent: _____
Occupation _____
Religious/Spiritual Preferences:
_____

Educational Background:_____

Emergency Contact:_____ Phone No._____

How did you hear about us?
☐ Former patient of practice
☐ AnotherPatient _____
☐ Course/Seminar Taught By _____
☐ Physician/Professional_____
☐ Internet _____

1801 NE 123 Street, Suite 415 North Miami, FL 33181
Phone: +1 305 935 8775 Fax: +1 305 705 2825

FINANCIAL AGREEMENT

I claim full financial responsibility for services rendered by Dr. Emmanuela Wolloch for _____ and understand that payment ***is*** required in **full** at the time of service. No insurance plans are accepted.

_____

that payment **is** required in full **at** the time of service.

SIGNATURE- PATIENT

_____

INTENTION FOR THIS APPOINTMENT-(What are the top 3 symptoms you would like help with today?)

_____

_____

_____

CURRENT/RECENT HEALTH CARE PROVIDERS/ PRIMARY CARE PHYSICIAN

Name Dates Care Provided

_____

_____

_____

GENERAL HEALTH

Excellent	Good	Fair	Poor
☐	☐	☐	☐

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PAST MEDICAL CONDITIONS (For **current** problems, note under Current Medical Problems, below.)

Breast Cancer	☐	Ovarian Cancer	☐	Other Cancer	☐
High Blood Pressure	☐	Varicose Veins	☐	Clotting Defects	☐
Bleeding Tendencies	☐	Heart Trouble	☐	Kidney Trouble	☐
Cervical Cancer	☐	Uterine Cancer	☐	Depression/Anxiety	☐
Stroke	☐	Phlebitis	☐	Rheumatic Fever	☐
Blood Transfusion	☐	Diabetes	☐	Osteoporosis	☐
Arthritis	☐	Epilepsy	☐	Eating Disorder	☐
Chronic Fatigue/Epstein Barr	☐	Asthma	☐	Environmental Illness	☐
Fractures	☐	Colitis	☐	Chemical Sensitivity	☐
Other	☐				

Vitamins/Supplements/Herbs

Vitamin	Used for

ALLERGIES

Drug allergies (penicillin, etc.):

_____

Allergies to foods, pollens, etc.:

_____

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MEDICATIONS

If this is a hormone consult, please list all hormones you have taken in the past, thyroid or adrenal hormones and all estrogen, progesterones, testosterone, Human Growth Hormone and DHEA.

Drug Name	When Used	Why Used	Side Effects

HOSPITALIZATIONS/OPERATIONS

Dates Hospital Diagnosis/Operation Doctor

_____

_____

_____

_____

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CURRENT MEDICAL SYMPTOMS/ CONDITIONS

*Circle any symptoms of **present** significance.*

GENERAL					
Fever or Chills	☐	Unusual hair growth	☐	Fatigue/low energy	☐
Hot flashes	☐	Skin changes	☐	Cold extremities	☐
Night Sweats	☐	Weight Change	☐	Cold Intolerance	☐

ABDOMEN					
Bloating	☐	Constipation	☐	Change in bowel habits	☐
Heartburn	☐	Hemorrhoids	☐	Vomiting	☐
Indigestion	☐	Flatulence (gas)	☐	Nausea	☐
Diarrhea	☐	Cramps or pain	☐	Bloddy or tarry stools	☐

HEAD					
Headaches	☐	Visual defects	☐	Sinus congestion	☐
Dizziness	☐	Hearing defects	☐	Fainting spells	☐

BLADDER and PROSTATE					
Frequent urination	☐	Inability to hold urine	☐	Painful urination	☐
Blood in urine	☐	Inability to empty bladder	☐	Nighttime urination	☐

CHEST					
Chest Pain	☐	Shortness of Breath	☐	Heart Murmur	☐
Mitral Valve Prolapse	☐	Palpitation	☐	Chronic Cough	☐
Coughing up Blodd	☐	Wheezing	☐		

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BREAST					
Lumps	☐	Bleeding	☐	Discharge	☐
Tenderness	☐	Other	☐		

FAMILY HISTORY

Family Member	Living	Age	Cause of Death/Age
Mother	Yes ☐ No ☐		
Father	Yes ☐ No ☐		
Sister(s)	Yes ☐ No ☐		
Brother(s)	Yes ☐ No ☐		
Maternal Grandparents	Yes ☐ No ☐		
Paternal Grandparents	Yes ☐ No ☐		
Maternal Aunt(s)	Yes ☐ No ☐		
Paternal Aunt(s)	Yes ☐ No ☐		
Maternal Uncle(s)	Yes ☐ No ☐		
Paternal Uncle(s)	Yes ☐ No ☐		

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	Mother	Father	Sister(s)	Brother(s)	Maternal Grandmother	Maternal Grandfather
Living, Age						
Alcholism	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabities	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐
Other Addiction	☐	☐	☐	☐	☐	☐
Domestic/Sexual Abuse	☐	☐	☐	☐	☐	☐

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	Paternal Grandmother	Paternal Grandfather	Maternal Aunt(s)	Paternal Aunt(s)	Maternal Uncle(s)	Paternal Uncle(s)
Living, Age						
Alcholism	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabities	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐
Other Addiction	☐	☐	☐	☐	☐	☐
Domestic/Sexual Abuse	☐	☐	☐	☐	☐	☐

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HABITS

Dietary preferences/restrictions	Yes ☐ No ☐		
What did you eat/drink in the past 3 days (include all snacks, sodas, water, alcohol, coffee, fast food etc.)			
Breakfast			
Lunches			
Dinners			
Snacks	☐	☐	☐
Drinks	☐	☐	☐
Have you ever been diagnosed with an eating disorder or feel like you may have one?			
Describe your body image:			
Routine physical exercise? Type of exercise:			
For how many minutes?		How often?	
Tobacco Use (how much?)		How often?	
Alcohol use (how much?)		How often?	
Caffeine use (how much?)		How often?	
Mood altering substance use? - PAST/PRESENT (i.e. marijuana, cocaine, prescription drugs)			
How often do you laugh?			
What do you do to nurture yourself?			
How do you express yourself creatively?			
What gives you joy/passion?			
Do you have a spiritual practice?			

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Stresses

Family, work, self, etc…

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