Exo-Regen Wellness

Patient Information:

Name: _____ **Date:** _____

Adress: _____

City: _____ **State:** _____**Zip Code:** _____

Phone: _____ **Cell:** _____ **Other:** _____

Date of Birth: _____ **(MM/DD/YY)** **Age:** _____ **Sex: M/F**

Occupation: _____ **Email address:** _____

In case of emergency, please contact: Name: _____**Phone:** _____

How did you hear about us? ____ **Internet** ____ **Facebook** ____ **Walk-in** ___ **Other:** _____

What are your man Complaints? **(Please check all that apply)**

___ **Asthma and Allergies**

___ **Brain fog or trouble concentrating**

___ **Cold or flu symptoms**

___ **Dull or dry skin**

___ **Facial wrinkles or fine lines**

___ **Fatigue or low energy**

___ **Headaches or migraines**

___ **Low mood or depression**

___ **Malabsorption issues**

___ **Poor diet due to busy lifestyle**

___ **Recent illness**

___ **Recent surgical procedure**

___ **Slow metabolism**

___ **Stress**

___ **Weight gain or difficulty losing weight**

___ **Other:** _____

What statements best describe why you are here today? **(Please check all the apply)**

___ **I want to have more energy and feel better overall**

___ **I want to enhance my weight loss efforts**

___ **I want to prevent getting sick**

___ **I want to slow the aging process**

___ **I want to feel and look younger**

___ **I want to cleanse my body of toxins**

___ **I want to recover quickly from (Hangover)**

___ **Other:** _____

PERSONAL MEDICAL HISTORY

PLEASE INDICATE ANY PREVIOUS OR CURRENT MEDICAL CONDITIONS AND DATE OF DIAGNOSIE:

Yes/No	MEDICAL CONDITION	DATE OF DIAGNOSIS
Yes/No	Angina/Chest Pain	Date: _____
Yes/No	Anxiety	Date: _____
Yes/No	Blood Clot	Date: _____
Yes/No	Bone Fracture	Date: _____
Yes/No	Cancer	Date: _____
Yes/No	Depression	Date: _____
Yes/No	Endometriosis	Date: _____
Yes/No	Fibrocystic Breast Disease	Date: _____
Yes/No	Heart Attack	Date: _____
Yes/No	Heart Disease	Date: _____
Yes/No	High Blood Pressure	Date: _____
Yes/No	Lupus	Date: _____
Yes/No	Migraine	Date: _____
Yes/No	Obesity	Date: _____
Yes/No	Rheumatoid Arthritis	Date: _____
Yes/No	Osteoporosis	Date: _____
Yes/No	Sleep Apnea	Date: _____
Yes/No	Sleep Apnea	Date: _____

Family MEDICAL HISTORY

PLEASE INDICATE ANY PREVIOUS OR CURRENT MEDICAL CONDITIONS AND DATE OF DIAGNOSIE:

Yes/No	MEDICAL CONDITION	RELATIONSHIP
Yes/No	Angina/Chest Pain	_____
Yes/No	Anxiety	_____
Yes/No	Blood Clot	_____
Yes/No	Bone Fracture	_____
Yes/No	Cancer	_____
Yes/No	Depression	_____
Yes/No	Endometriosis	_____
Yes/No	Fibrocystic Breast Disease	_____
Yes/No	Heart Attack	_____
Yes/No	Heart Disease	_____
Yes/No	High Blood Pressure	_____
Yes/No	Lupus	_____
Yes/No	Migraine	_____
Yes/No	Obesity	_____
Yes/No	Rheumatoid Arthritis	_____
Yes/No	Osteoporosis	_____
Yes/No	Sleep Apnea	_____

MEDICAL HISTORY

Date of last chemistry screen or other Lab Testing Date: _____

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(Please check all that apply)

___ **Hypermagnesemia (High magnesium levels)**

___ **Hypercalcemia (High calcium levels)**

___ **Hypokalemia (Low potassium levels)**

___ **Hemochromatosis (High iron levels)**

___ **Other:** _____

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If yes, how much do you smoke? _____

How many alcoholic drinks do you consume in a week? _____

Do you use recreational drugs? Yes / No If yes, which ones and how often? _____

_____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

_____

_____

_____

Over the Counter Drugs – Strength – Frequency – Condition being treated

_____

_____

_____

Vitamins and Other Supplements – Strength – Frequency – Condition being treaded

_____

_____

_____

MEDICAL HISTORY

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If yes, please list: _____

Do you take any steroids, i.e. Prednisone? Yes / No If yes, please list: _____

Do you have any medication or food allergies? Yes / No If yes, please list: _____

_____

Do you have any of the following conditions? (Please check all that apply)

___ Asthma

___ Blood Pressure (High or Low)

___ G6PD Deficiency

___ Heart Problems

___ Kidney Problems

___ Kidney Stones

___ Optic Nerve Atrophy or Leber's Disease

___ Parathyroid Problems (High Levels)

___ Sarcoidosis

___ Sickle Cell Anemia

List any other medical conditions you have not mentioned above:

_____

_____

_____

List of all surgical procedures you've had with approximate dates:

_____

_____

_____

Is there anything else you'd like the physician or nurse to know?

_____

_____

_____