GENETIX
HEALTH INSTITUTE

Lauren Huffman, NP
8226 Douglas Ave, Suite 704, Dallas, Texas 75225
O: (972) 236-3300 - F: (972) 739-3533

# PATIENT INTAKE FORM

Name_____Sex: M F DOB_____/_____/_____
Address_____Zip code _____
Email Address_____ Phone Number_____
Ethnicity: Caucasian, Hispanic, African-American, Asian, Native American, Middle Eastern, Other:_____
Height_____ Current Weight_____ Ideal Weight _____
Emergency Contact/Relationship _____
Emergency Contact Phone Number_____
How did you hear about Genetix Health Institute?_____
_____

What are Your **Age Management Medical Goals**: (check all that apply)

| | | |
|---|---|---|
| □ Lose Weight | □ Lose Body Fat | □ Other |
| □ Gain Muscle | □ Maximize Longevity | |
| □ Better Sex/Libido | □ Increase Energy | |

Past **Medical History** (i.e. high blood pressure, heart disease, diabetes, vaccinations in last two years including flu shots, etc.)_____

_____

Past **Surgical History**:_____

_____

| **Current Medications : (name and dosage)** | **Current Supplements :** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**Medication Allergies/Other allergies:**_____

**Pharmacy Name & Phone number:**_____

## FAMILY HISTORY

According to the key, place in the box who in your family has had: KEY: (Mother)-M, (Father)-F, (Sibling)-S, (Grandmother)-GM, etc.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies | | Drug Abuse | | Gout | | Osteoarthritis | |
| Amalgams(silver fillings) | | Depression | | Hepatitis | | Osteoporosis | |
| Arteriosclerosis | | Diabetes | | Heart Disease | | Psoriasis | |
| A.D.D. | | Eczema | | Heart Attack | | Rheumatoid Arthritis | |
| Alzheimer's | | Early puberty | | High Blood Pressure | | Stomach Ulcer | |
| Asthma | | Epilepsy | | Adult onset Diabetes | | STDs (venereal disease) | |
| Autoimmune disorders | | Epstein Barr Virus | | Mental Illness | | Stroke | |
| Acne | | Fatigue | | Migraines | | Thyroid Disease | |
| Cancer | | Gallstones | | Multiple Sclerosis | | Kidney Disease | |
| Candida | | Goiter | | Obesity | | Lupus | |
| Crown's | | Colitis | | Diverticulitis | | Irritable bowel | |
| Parkinson's | | Liver Disease | | Bladder Disease | | Anemia | |
| Sleep Apnea | | HIV | | | | | |

List any other disease/condition in your family and relationship:_____

## MEDICAL HISTORY

| | | | | |
|---|---|---|---|---|
| Headaches (Migraines) | | | Heart Disease | |
| Seizure Disorder | | | Chest Pain | |
| Recurrent Sinus Infections | | | Irregular Heartbeat | |
| Seasonal Allergies | | | High Blood Pressure | |
| Emotional/Psychiatric Illness | | | Blood Clotting Problems | |
| Depression | | | Bleeding Disorder | |
| Anxiety/Excessive Stress | | | Stroke/Vascular Disease | |
| Asthma | | | Kidney Disease | |
| Chronic Bronchitis | | | Menstrual Disorders | |
| Lung/Breathing Problems | | | Reproduction Problems | |
| Chronic Indigestion | | | Prostate Problems | |
| Stomach Ulcers | | | Sexual/Libido Problems | |
| Back Pain/Sciatica | | | Tendinitis | |
| Herniated Disc | | | Chronic Pain | |
| Neck Pain | | | Shoulder Problems | |
| Chronic Muscle/Joint Pain | | | Osteoarthritis | |
| Carpal Tunnel Syndrome | | | Rheumatoid Arthritis | |
| Fibromyalgia | | | Artificial Joints | |
| Diabetes | | | Cancer | |
| Thyroid Disease | | | Psoriasis or Eczema | |
| Osteoporosis/Osteopenia | | | Other (please list below) | |
| | | | | |
| | | | | |

List any additional health problems not listed above: _____

_____

HEALTH SCREENINGS

| Test | Yearly | Past 1 -2 years | Past 5 years | Never | Result OK √ | If not okay – Comment |
|---|---|---|---|---|---|---|
| Pap Smear | | | | | | |
| Pelvic Exam | | | | | | |
| Breast exam | | | | | | |
| Mammogram | | | | | | |
| Colonoscopy | | | | | | |
| Sigmoidoscopy | | | | | | |
| Rectal exam | | | | | | |
| Resting EKG | | | | | | |
| Stress EKG | | | | | | |
| Stress echo | | | | | | |
| Nuclear Stress | | | | | | |
| Chest x-ray | | | | | | |
| Eye exam/Eye Pressure | | | | | | |

**MALE PATIENTS**

Last PSA: _____ Results:_____

Any Sexual Dysfunction? Yes / No What?_____

Any history of Prostate Dysfunction? Yes / No _____

Did your father have prostate problems? Yes / No _____

Any history of cancer any type? Yes / No _____

| Do you Experience or Have | Check if YES | | Do you Experience or Have | Check if YES |
|---|---|---|---|---|
| Balding | | | Urethral discharge | |
| Lethargic during day | | | Poor muscle mass | |
| Memory loss | | | Enlarged breast, nipples | |
| Impotent | | | Sexually active | |
| Premature ejaculation | | | Scars-where | |
| Loss of sexual orgasm | | | Depression | |
| Loss of libido | | | Osteoporosis | |
| Testicular pain | | | Joint pain | |
| Urinary tract infections | | | Bellybutton/groin bulge | |
| Erectile dysfunction | | | Hemorrhoids | |

## FEMALE PATIENTS

Last Mammogram:_____ Results_____ Breast Implants? Y / N

Last Pap Smear:_____ Results_____

Last Menstrual Cycle:_____ *Circle:* Pre- Post Peri-Menopausal

Menopause: Yes / No At what age?_____

Are You Pregnant? Yes / No

Breast Tender or Swollen Two Weeks before period? Yes / No

Puberty: Early / Late At what age did you begin menstruating? _____

Date of Hysterectomy (if applicable) _____ Complete Partial

Have you experienced lumps, tenderness, pain, changes, other:_____

Any History of Breast Disease or cysts? No Yes explain:_____

Any history of thyroid dysfunction? No Yes explain:_____

Any history of cancer of any type? No Yes explain:_____

| **Do You Experience or Have** | **Y** | | **Do You Experience or Have** | **Y** | |
|---|---|---|---|---|---|
| Thinning Hair | | | Painful cramps during period | | |
| Lethargic during day | | | Sexual dysfunctions | | |
| Memory loss | | | Sexually active | | |
| Decreased libido | | | Insomnia | | |
| Vaginal dryness/burning | | | PMS | | |
| Yeast/urinary tract infections | | | Pregnant | | |
| Vaginal Discharge | | | Number of children | | |
| Uncomfortable cold/hot | | | Weight gain / loss | | |
| Hot flashes? Night sweats? | | | Depression/Anxiety/Mood Swings | | |
| Regular or irregular periods? *Circle one* | | | Osteoporosis | | |
| Irritable or depressive before your period | | | Discomfort during sex/painful intercourse | | |
| Carbohydrate cravings | | | Abdominal fat | | |
| Urinary incontinence | | | Joint Pain | | |

***List Any Hormones taken in past:***

_____

_____

_____

_____

**Primary care physician & Phone number:**_____

**Any Specialists Physicians:**_____

_____

| *In my opinion:* | *circle all that apply:* | | | |
|---|---|---|---|---|
| **My health is:** | Excellent | Good | Fair | Poor |
| **My nutrition intake is:** | Excellent | Good | Fair | Poor |
| **My physical fitness is:** | Excellent | Good | Fair | Poor |
| **My stress level is:** | Low | Moderate | High | |

**Tobacco History:**

_____ I have never smoked cigarettes or chewed tobacco

I now smoke_____ packs of cigarettes a day. I have smoked for _____ years.

I quit smoking in the year of_____. I smoked _____ packs/day for _____ years.

_____I smoke cigars/pipe

_____I chew tobacco

**Alcohol History:**

_____I never drink alcohol

____ I drink occasionally/socially

_____ I regularly drink _____ alcoholic drinks a day

____I have a family history of alcoholism

## NUTRITION

**Dietary Habits:** *Circle All That Apply*

No Special Diet Habits  Avoid Red Meats  Minimize Fat  Minimize Carbs  Vegetarian

Emphasize Fruit/Veggies  Try to Eat Healthy  Avoid Dairy/Cheese  Vegan  Gluten Free

I commonly eat at fast food restaurants  I commonly eat prepackaged foods

I commonly consume:  Coffee  Soft Drinks  Diet Drinks  Candy/Chocolate  Chips/Crackers

| | |
|---|---|
| My typical Snack : | |
| Number of Meals Daily | |
| Protein Intake | Please circle: Red Meat White Meat Pork Game Tofu Soy Protein |
| Fish | Please circle: Smoked Cooked in Oil or Butter Boiled or Steamed Raw |
| Fat Intake | Please circle: Olive Oil Coconut Nut Oils Fried Foods Other: |
| Vegetables | Yes / No Raw Boiled Cooked in Oil or Butter Canned |
| Carbohydrate Intake | Please Circle: Low Medium High Grains? Yes / No Root Vegetables? Yes / No |
| Special diet | Please describe: Low-Fat High-Protein Mediterranean Adkins Other: |
| Sweeteners | Please circle: Sweet N' Low Splenda NutraSweet(equal) Cane Sugar Honey Jam |
| Sweets | Please circle: Candies Cakes Cookies Other: |
| Do you eat fruit ? | Yes / No What Type? |
| Water | Please circle: Spring Distilled Tap Bottled how many 8 ounce glasses daily? |
| Milk products | Please circle: Milk Buttermilk Yogurt Cheese Cottage Cheese Butter |
| Soft drinks | How many per day? |
| Coffee/Tea | How many per day? Organic What Type Tea? Herbal Black Green Flavored |
| Juices | How many per day? Organic What Type? |
| Alcoholic drinks | Please circle: Beer Wine Strong Alcohols (Cognac, Vodka, Whiskey) |
| Cravings | Please circle: Sweet Salty Fatty Breads Pasta |

## FITNESS SUMMARY

**Exercise Habits:** *Circle All That Apply*

No Exercise Habits  I Routinely Exercise____ Hrs. ___ Times a week

| | | | |
|---|---|---|---|
| Aerobic exercise | Dance | Stationary bike | Spin class |
| Resistance training | Run | Martial arts | Gardening |
| Tai chi | Jog | Yoga | Housework |
| Walking | Cycle | Pilates | Gymnastics |
| Brisk walking | Stretching exercises | Zumba | Wrestling |
| Swim | Strength training | Water aerobics | Strenuous calisthenics |

Other:_____

# HIPAA

By signing this form, I acknowledge that I have received the notification of privacy practice.

I herby authorize the disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be disclosed and no longer protected by federal privacy regulations.

Please check on of the following:

_____ You do not have permission to discuss my medical information with any other person.

_____ You have permission to discuss my medical information with the persons listed below.

_____ _____

Name Relationship

_____ _____

Name Relationship

Conventional email and text messages are not considered HIPAA compliant means of communication. Often, these are the most convenient forms of communication with our busy lives. Please indicate communication preference:

Non-HIPAA Compliant Email _____ (initial if accepting this form of communication)

Standard Text Messaging _____(initial if accepting this form of communication)

_____

**Signature**

_____

**Printed Name**

_____

**Date**