MILLENNIUM
HEALTH & WELLNESS

New Patient Wellness Evaluation

From a clinical point of view, it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow the practitioner to maintain your medical history and will help in advising about current medical therapies. All information provided will be kept confidential.

GENERAL INFORMATION Date_____

Name: _____ Age: _____ Birth Date: _____Sex:_____

Street Address: _____Apt._____

City: _____ State: _____ Zip: _____

Social Security #: _____

Phone Day: _____ Evening: _____

Email Address: _____

Occupation_____

In Case of Emergency, Contact_____Ph #_____Relationship:_____

Living Situation: Spouse___ Alone___ Partner___ Friend___ Parents___ Children___ Other___

Status: Married___ Single___ Divorced___ Widowed___

INSURANCE

Who is responsible for this account? _____ Relationship to Patient_____

Insurance Co._____ Policy #_____ Grp #_____

Subscribers Name_____ Birthdate_____ SS#_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with above stated insurance company and assign directly to Millennium Health & Wellness all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____ Date_____

Responsible Party Signature Relationship

Employee Initials:_____

MEDICAL STATUS

Primary Health Care Practitioner/Physician: _____ Phone: _____

Address: _____ Fax: _____

General Health: Excellent___ Good___ Fair___ Poor___ Height: _____ Weight: _____

Allergies: _____

Current Diagnosis or Medical Conditions: _____

Current Medications: _____

Current Vitamins or OTC products: _____

Current Herbs, etc.:_____

Are you currently or Natural Progesterone Cream? YES___ NO____

Bone Density: YES___ NO___ Osteopenia? Osteoporosis?

Date of last mammogram: _____ Results: _____

Have you had your thyroid tested? YES____ NO____ Results: _____

FAMILY HISTORY

RELATIVE	BREAST CANCER	HEART DISEASE	DIABETES
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandma			
Paternal Grandpa			
Maternal Grandma			
Maternal Grandpa			

HEALTH HISTORY

What treatment have you already received for your condition? ❑Medications ❑Surgery ❑Physical Therapy ❑Chiropractic ❑None ❑Other_____

Name and address of other doctor(s) who have treated you for your condition _____

_____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT Scan, Bone Scan_____

Employee Initials:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	❑Yes ❑No	Glaucoma	❑Yes ❑No	Pinched Nerve	❑Yes ❑No
Alcoholism	❑Yes ❑No	Goiter	❑Yes ❑No	Pneumonia	❑Yes ❑No
Allegery Shots	❑Yes ❑No	Gonorrhea	❑Yes ❑No	Polio	❑Yes ❑No
Anemia	❑Yes ❑No	Gout	❑Yes ❑No	Prostate Problem	❑Yes ❑No
Anorexia	❑Yes ❑No	Heart Disease	❑Yes ❑No	Prosthesis	❑Yes ❑No
Appendicitis	❑Yes ❑No	Hepatitis	❑Yes ❑No	Psychiatric Care	❑Yes ❑No
Arthitis	❑Yes ❑No	Hernia	❑Yes ❑No	Rheumatoid Arthritis	❑Yes ❑No
Asthma	❑Yes ❑No	Herniated Disc	❑Yes ❑No	Rheumatic Fever	❑Yes ❑No
Bleeding Disorders	❑Yes ❑No	Herpes	❑Yes ❑No	Scarlet Fever	❑Yes ❑No
Breast Lump	❑Yes ❑No	High Cholesterol	❑Yes ❑No	Stroke	❑Yes ❑No
Bronchitis	❑Yes ❑No	Kidney Disease	❑Yes ❑No	Suicide Attempt	❑Yes ❑No
Bulimia	❑Yes ❑No	Liver Disease	❑Yes ❑No	Thyroid Problems	❑Yes ❑No
Cancer	❑Yes ❑No	Measles	❑Yes ❑No	Tonsillitis	❑Yes ❑No
Cataracts	❑Yes ❑No	Migraine Headaches	❑Yes ❑No	Tuberculosis	❑Yes ❑No
Chemical Dependency	❑Yes ❑No	Miscarriage	❑Yes ❑No	Tumors, Growths	❑Yes ❑No
Chicken Pox	❑Yes ❑No	Monoucleosis	❑Yes ❑No	Typhoid Fever	❑Yes ❑No
Diabetes	❑Yes ❑No	Multiple Sclerosis	❑Yes ❑No	Ulcers	❑Yes ❑No
Emphysema	❑Yes ❑No	Mumps	❑Yes ❑No	Vaginal Infections	❑Yes ❑No
Epilepsy	❑Yes ❑No	Osteoporosis	❑Yes ❑No	Venereal Disease	❑Yes ❑No
Fractures	❑Yes ❑No	Pacemaker	❑Yes ❑No	Whooping Cough	❑Yes ❑No
Glaucoma	❑Yes ❑No	Parkinson's Disease	❑Yes ❑No	Other_____	❑Yes ❑No

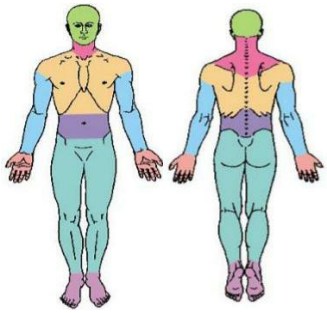
Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ❑Yes ❑No ❑Unknown

Mark an X on the picture where you continue to have pain, numbness, or, tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____



Type of pain: ❑Sharp ❑Dull ❑Throbbing ❑Numbness ❑Aching ❑Shooting ❑Burning ❑Tingling ❑Cramps ❑Stiffness ❑Swelling ❑Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your: ❑Work ❑Sleep ❑Daily Routine ❑Recreation

Activities or movements that are painful to perform: ❑Sitting ❑Standing ❑Walking ❑Bending ❑Lying Down

Employee Initials:_____

EXERCISE	WORK ACTIVITY	HABITS	
❑Never	❑Sitting	❑Smoking	Packs/Day_____
❑Rarely	❑Standing	❑Alcohol	Drinks/Week_____
❑Occasionally	❑Light Labor	❑Coffee/Caffeine Drinks	Cups/Day_____
❑Regularly	❑Heavy Labor	❑High Stress Level	Reason_____
❑Type_____			

Are you pregnant? ❑Yes ❑No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATION	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name_____	_____	_____
Pharmacy Name_____	_____	_____

Employee Initials:_____