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A Medical Corporation
Fellow American College of Chest Physicians

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Board Certified: Pulmonary Medicine **Fax: (949) 721-9121**
Board Certified: Anti-Aging Medicine **Email:office@newportlongevity.net**

Medical and Personal History

Date: _____ Name: _____ Date of Birth: _____

Address: _____

Email: _____Cell (or preferred #):_____

(For office use only) B.P. _____ P. _____ M / F _____ Ht. _____ Wt. _____

Patient Information:

I. Medical problems (please number, as applicable, in order of severity):

- Heart Disease_____
- Hypertension/High Blood Pressure_____
- Diabetes_____
- Asthma_____
- Stroke_____
- Chest pain/pressure_____
- Acid Reflux (heartburn) /ulcers_____
- Back pain_____
- Knee/foot pain_____
- Joint pain (other)_____
- High cholesterol_____
- Shortness of breath_____
- Sleep Apnea_____
- Abdominal Pain _____
- Chronic Bronchitis/Emphysema_____
- Chronic Fatigue_____
- Cancer_____
- Other (please describe): _____

II. Occupational history (past 10 years):

A. Type of business: _____

B. Job title: _____

C. Are you currently working? Yes_____ No_____; If not, when did you last work? _____
D. Number of hours worked each week? _____
E. Number of days worked each week? _____
F. Are you disabled? Yes_____ No_____
G. Previous jobs/occupations:
1._____ 2._____

III. Previous surgeries or hospitalizations (and dates):

A. _____

B. _____

C. _____

IV. Allergies (foods, drugs, animals, chemicals, etc.):

_____

V. Current medications and supplements (daily dosage):

A. _____ D. _____

B. _____ E. _____

C. _____F. _____

VI. Smoking History:

- Have you ever smoked? Yes_____ No_____
- If yes, how many packs a day? _____
- Total number of years smoked _____
- Are you smoking now? Yes_____ No_____
- At what age did you start smoking? _____
- When did you quit smoking? _____

VII. Risk factors for heart disease (please check):

- Smoking _____
- Obesity_____
- High cholesterol_____
- Emotional stress _____
- Diabetes _____
- Hypertension _____
- Family history of heart disease _____

VIII. Stress History:

A. Please give examples of sources of stress in your life:

- Job/business_____
- Family _____
- Health _____
- Finances _____
- Other _____

B. Do you feel that any of these have contributed to your medical problems?
Yes____ No_____

IX. Family History:

A. Age of mother: _____ If deceased, cause of death: _____
B. Age of father: _____ If deceased, cause of death: _____
C. Please list family members who have, or had, any of the following major diseases:

Heart disease _____

Stroke _____

Hypertension _____

Diabetes _____

Cancer _____

Other? _____

X. Social History:

Marital status: _____ Length of marriage: _____

Number of children: _____ Level of education: _____

Alcohol intake: # of drinks: daily? ____ weekly? ____ monthly? ____

XI. Dietary History:

- Number of meals per day_____
- Main meal: breakfast_____ lunch _____ dinner _____
- Latest you eat at night _____
- Approximate# of calories per day _____
- Food group (% estimate) : protein_____ carbohydrates _____ fat _____
- Number of glasses of water per day _____
- Ideal body weight _____
  High school weight _____
  Young adult weight _____
  Weight goal (if any) _____

XII. Exercise Program:

- Frequency (#times/week) _____
- Duration _____
- Intensity: low_____ moderate _____ high _____
- Any breathlessness or muscle fatigue? Yes_____ No____ Sometimes _____
- Form of exercise (please check): running ___walking ____weight training ___ cycling _____ Yoga _____ Pilates _____ stationary bike _____ swimming ___ other _____

XIII. How were you referred to our office? _____

What is the primary purpose of your initial visit and what are your health goals?

☐ physiologic profile

☐ reduce or eliminate need for medication

☐ improve performance/energy levels

☐ reduce or eliminate joint pain

☐ improve exercise tolerance

☐ hormone replacement

☐ reduce risk of heart attack

☐ improve overall health

☐ improve sleep

☐ weight loss

☐ increase lifespan

☐ stress management

☐ other _____

XV. (Females only)

1. When was your last menstrual period? (date) _____
2. How many pregnancies have you had? _____
3. How many children have you had? _____
4. Are you currently taking any hormones? Yes_____ No_____
   If yes, which ones and what is the dosage? _____
   _____

5. Have you taken hormones in the past? Yes _____ No _____
   If so, which ones and when? _____
   _____