REVOLUTION

WELLNESS & PREVENTION CLINIC

AMITY SMITH, MD ~ SOUTHLAKE, TX ~ 817-488-2837

Date: _____

Name: _____ **Date of Birth:** _____

Phone: _____ **Email:** _____

Address: _____

_____

_____

How did you hear about Revolution? _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Occupation: _____ Employer: _____

Job Description: _____

What are the most important concerns you want to address to Dr. Smith?

Hormone balance		Anxiety		Weight gain or loss	
Low energy levels		Pain		Attention	
Low libido		Other		Concentration	
Depression		Insomnia		Wellness	

Medical History

Current Medical Conditions:

Hospitalizations: None

Surgeries: None

Genetic History:

Mother Age: _____ Disease? _____ Weight: _____ Height: _____

Father Age: _____ Disease? _____ Weight: _____ Height: _____

Sibling Age: _____ Disease? _____ Weight: _____ Height: _____

Sibling Age: _____ Disease? _____ Weight: _____ Height: _____

Sibling Age: _____ Disease? _____ Weight: _____ Height: _____

Are you currently under the care of any other physicians? Yes No

If yes, list names and scope of treatment:

_____

_____

_____

Please Circle any symptoms

Fatigue
Weight gain
Weight loss
Fever/Chills
Weakness

Runny nose
Allergies
Ear pain
Sore throat
Sneezing

Headaches
Migraines
Dry Hair
Dry skin
Dry eyes
Cold hands/feet
Always cold
Heat intolerance
Can't lose weight

Heavy periods
Irregular periods
Hot flashes
Breast tenderness
Breast lump
Vaginal dryness
Difficult PMS
Low libido
Cellulite
Difficulty with orgasm

Muscle weakness
Abdominal obesity
Bloating
Swelling
Ineffective work-outs
More time needed to recover
Harder to gain muscle mass
Erection more difficult
Lack of motivation to exercise

Anxiety
Depressed mood
Poor memory
Insomnia
Difficulty concentrating
Difficulty waking up
Disorganization
Lack of drive or focus
Low energy
Lack of motivation
Nervousness
Phobias

Chest pain
Shortness of breath
Palpitations
Coughing
Wheezes

Nausea
Vomiting
Constipation
Diarrhea
Indigestion
Stomach pain
Bloating or gas

Muscle pain
Joint pain
Swelling
Back pain
Neck pain

Dizziness
Numbness
Light headedness
Tremors

Other Symptoms:

_____
_____
_____

Current Medications and/or Supplements, list dose and frequency

Past Medications and/or Supplements, list dose and frequency (past 5 years)

Allergies and intolerances: (drug, food, environment)

Immediate Family and Kids

Married Yes No Spouse: _____ How many years: _____

Relationship: Good (10) Bad (1) 1 2 3 4 5 6 7 8 9 10

Divorce: Yes No Single Relationship

Children 1 2 3 4 __ (name, age, sex)

1) 3)

2) 4)

Hobbies and Preferences:

What do you do for fun? _____

What do you do that is creative? _____

What do you do to challenge your brain? _____

What do like to do for exercise? _____

What are your favorite foods? _____

What are foods that you hate? _____

What meats/seafoods do you like? _____

What are your favorite restaurants? _____

Do you have a religious preference? _____ Church: _____

What do you do to nourish your spirit? _____

How many alcoholic drinks to you have in a week? _____

Do you prefer? Beer Wine Spirits Other: _____

Have you ever smoked? Yes No Currently? Yes No

When did you quit? _____ Any other tobacco exposure? _____

Any other habits that are relevant?

_____