Jaime A Salas Rushford MD

Patients Demographics and Health Questionnaire

DATE: _____ Primary Care Physician: _____

Last Name: _____ Second Last Name: _____

Name: _____ Middle Name: _____

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER: _____

HOME ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP CODE: _____

PRIMARY PHONE: _____ E-Mail Address: _____

AGE: _____ DATE OF BIRTH: MONTH: _____ DAY: _____ YEAR: _____

HEIGHT: _____ HEIGHT @ 20 YEARS: _____ WEIGHT: _____ WEIGHT @ 20 YEARS: _____

AT WHAT BODY WEIGHT DO YOU FELT BETTER: _____

IN CASE OF EMERGENCY CONTACT:

CONTACT NAME: _____ RELATIONSHIP: _____

PHONE: _____

NEXT PAGE

[*Next Page*]

TREATING PHYSICIAN INFORMATION

PRIMARY CARE	SPECIALIST # 1	COACH / TRAINNER
NAME: _____	NAME: _____	NAME: _____
SPECIALTY: _____	SPECIALTY: _____	SPECIALTY: _____
ADDRESS: _____	ADDRESS: _____	ADDRESS: _____
_____	_____	_____
_____	_____	_____
PHONE: _____	PHONE: _____	PHONE: _____
E-Mail:	E-Mail:	E-Mail:
_____	_____	_____

Are you a professional Athlete? YES [ ] NO [ ], if YES, please indicate sport and to what league do you belong.

_____

Have you ever used anabolic steroids? YES [ ] NO [ ], if YES, please indicated the treating physician and associated diagnosis.

_____

Are you in your: Pre-Season [ ], Competition Period [ ], Post- Season [ ] or Injury Leave [ ]

Please complete the following medical questionnaire to the best of your knowledge. It is very important, since it helps our medical staff better understand your present and past medical conditions. If you have recent laboratory results or diagnostics studies that you feel might help in your treatment, please attached them when returning this questionnaire.

NEXT PAGE

[*Next Page*]

Patients Demographics and Health Questionnaire

PLEASE DESCRIBE WHAT MADE YOU SEEK OUR MEDICAL EVALUATION AND WHAT EXPECTATIONS YOU HAVE:

_____

_____

_____

_____

_____

If available from your most recent primary care visit or medical evaluation, please complete the section below of vital signs and body composition.

Vital Signs & Body Composition

BP (Blood Pressure): _____ **HR (Heart Rate): _____**

O2 Saturation: _____ **BMI (Body Mass Index): _____**

HEIGHT: _____ **ACTUAL BODY WEIGHT: _____**

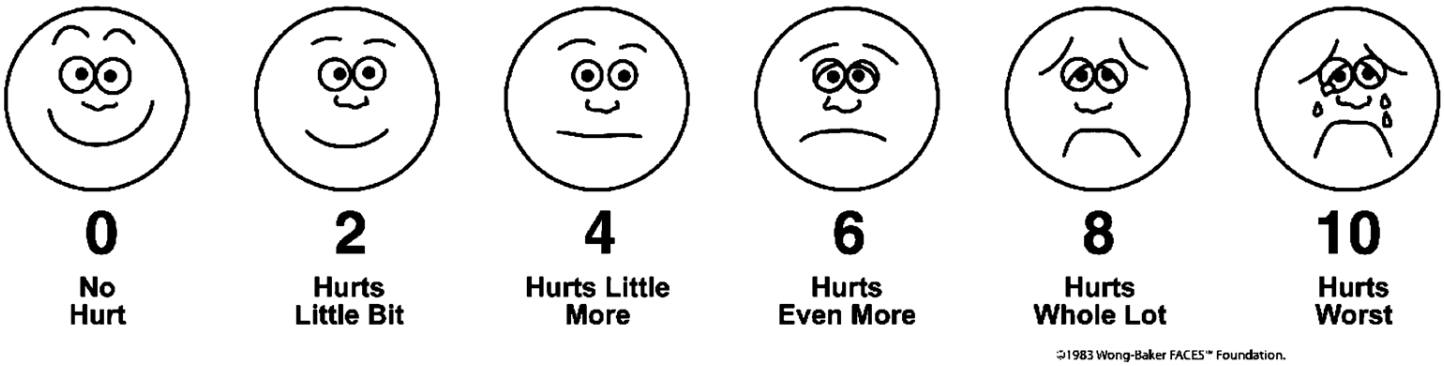
WAIST: _____ **NECK CIRCUMFERENCE: _____**

NEXT PAGE

[*Next Page*]

PAIN SCALE: Please CIRCLE the appropriate FACE in relation as how you feel today.

Wong-Baker FACES™ Pain Rating Scale



NEXT PAGE
[*Next Page*]

MEDICAL HISTORY

Current Medical conditions

Medical Condition	Year and Age of Diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	

NEXT PAGE

[*Next Page*]

PLEASE IDENTIFY, any surgeries of procedures that you have undergone.

	YES	NO	YEAR
1. GALLBLADDER	[ ]	[ ]	_____
2. APPENDECTOMY	[ ]	[ ]	_____
3. HEMORROID Surgery	[ ]	[ ]	_____
4. OVARIAN / GYN	[ ]	[ ]	_____
5. UTERUS Surgery	[ ]	[ ]	_____
6. HERNIAS	[ ]	[ ]	_____
7. BLADDER	[ ]	[ ]	_____
8. HEART	[ ]	[ ]	_____
9. DIGESTIVE / COLON	[ ]	[ ]	_____
10. BREAST MASS	[ ]	[ ]	_____
11. TRANSGENDER SURGERY	[ ]	[ ]	_____
12. VARICOSE VEINS	[ ]	[ ]	_____
13. PROSTATE	[ ]	[ ]	_____
14. KIDNEYS	[ ]	[ ]	_____
15. LUNGS	[ ]	[ ]	_____

16. OTHER: _____

a._____

b._____

NEXT PAGE
[*Next Page*]

Family History	
Medical Condition	**Relationship**
Breast Cancer	
Prostate Cancer	
Uterine Cancer	
Ovarian Cancer	
Fibrocystic Breast Disease	
Coronary / Heart disease	
Cerebrovascular Disease / Stroke	
Diabetes	
Hypertension	
Osteoporosis / Osteopenia	
Alzheimer Dementia	
Other: Please specify	

Medications & Supplements used currently or in the past 6 months		
Name of Medication / Supplement	Dosing and Frequency	Indication

NEXT PAGE

[*Next Page*]

SOCIAL HISTORY

	YES	NO	PLEASE SPECIFY:		
Alcohol	[ ]	[ ]	☐ Wine	☐ BEER	☐ HEAVY ALCOHOL
Drugs	[ ]	[ ]			
Tobacco	[ ]	[ ]			
Coffee	[ ]	[ ]			

ALLERGIES

Medications: _____

Type of Reaction: _____

Food and / or Supplements: _____

Type of Reaction: _____

NEXT PAGE →

[*Next Page*]

PLEASE INDICATE IF YOU HAD ANY OF THE FOLLOWING IN THE PAST 6 MONTHS or ARE HAVING ANY CURRENTLY:

Stomach, Liver, Pancreas, or Digestive System:

	YES	NO
1. Pain or Difficulty While Swallowing	[ ]	[ ]
2. Frequent Diarrhea	[ ]	[ ]
3. Epigastric Pain	[ ]	[ ]
4. Frequent Nausea	[ ]	[ ]
5. Vomiting Blood	[ ]	[ ]
6. Frequent Indigestion	[ ]	[ ]
7. Frequent Bloating or Gas	[ ]	[ ]
8. Jaundice	[ ]	[ ]
9. Gastric Ulcers	[ ]	[ ]
10. Hepatitis	[ ]	[ ]
11. Gallbladder Disease	[ ]	[ ]
12. Liver Cirrhosis	[ ]	[ ]
13. Frequent Diarrhea	[ ]	[ ]
14. Acute weight loss; How Many Pounds _____	[ ]	[ ]
15. Celiac or Malabsorption	[ ]	[ ]
16. Stomach Pain	[ ]	[ ]
17. Intestinal Spasms or Pain	[ ]	[ ]
18. Lactose Intolerance	[ ]	[ ]
19. Esophageal Hernia	[ ]	[ ]
20. Intestinal Adhesions	[ ]	[ ]
21. Intestinal Obstructions	[ ]	[ ]
22. Hemorrhoids	[ ]	[ ]
23. Rectal Bleeding	[ ]	[ ]

NEXT PAGE

[*Next Page*]

Skeletal Muscle & Joints	YES	NO
1. Joint Pain	[ ]	[ ]
2. Joint Swelling	[ ]	[ ]
3. Venous or Circulatory Insufficiency	[ ]	[ ]
4. Herniated Discs	[ ]	[ ]
5. Have You Needed Intra-Articular Injections?	[ ]	[ ]
6. Do You Require Regular Anti-Inflammatory Medication	[ ]	[ ]
7. Have You Taken Cortisone for Joint Pain	[ ]	[ ]

Blood Vessels & Circulation	YES	NO
1. Do You Suffer from Varicose Veins	[ ]	[ ]
2. Have You had Phlebitis	[ ]	[ ]
3. Do You Suffer from Recurrent Arm or Leg Swelling	[ ]	[ ]
4. Do Suffer from Painful Legs While You Sleep	[ ]	[ ]
5. Do Your Legs Swell Up or Hurt After Walking a Short Distance	[ ]	[ ]

Both Males & Females	YES	NO
1. Burning or Painful Voiding	[ ]	[ ]
2. Do You Have to Strain While Voiding	[ ]	[ ]
3. Frequent Voiding @ Night How Many Times: _____	[ ]	[ ]
4. Do You See Blood in Your Urine	[ ]	[ ]
5. Do You Suffer from Urinary Incontinence	[ ]	[ ]
6. Do You Perceive a Strong or Bad Odor in Your Urine	[ ]	[ ]
7. Do You Notice Increase Voiding Frequency. How Many Times___	[ ]	[ ]
8. Do You Suffer from Frequent Episodes of Cystitis	[ ]	[ ]
9. Do You Have Renal Stones	[ ]	[ ]

NEXT PAGE
[*Next Page*]

Patients Demographics and Health Questionnaire

Male Patients	YES	NO
1. Have You Had Penile Secretions	[ ]	[ ]
2. Have You Had Testicular Discomfort or Pain	[ ]	[ ]
3. Have You Had a Testicular Mass	[ ]	[ ]
4. Have You Suffered from Erectile Dysfunction	[ ]	[ ]
5. Have You Had Prostate Disease or Have Been Treated for Such	[ ]	[ ]

Female Patients	YES	NO
1. Do You Still Have Your Menstrual Period	[ ]	[ ]
2. Do You Suffer from an Irregular Menstrual Period	[ ]	[ ]
3. Do You Suffer from Painful Menses	[ ]	[ ]
4. Have You Ever Been Pregnant	[ ]	[ ]
5. Are You Currently Pregnant or Think You Might Be	[ ]	[ ]
6. Have You Ever Been Diagnosed with PCOS (Polycystic Ovaries)	[ ]	[ ]
7. Have You Ever Been Treated for Infertility	[ ]	[ ]
8. Have You Taken or Currently Take Oral Contraceptive Pills	[ ]	[ ]
9. Do You Have or Have Had an Intrauterine Device	[ ]	[ ]
10. Do You Suffer From Hirsutism	[ ]	[ ]
11. Have You Been Diagnosed or Treated for Endometriosis	[ ]	[ ]
12. Have You Had or Been Treated for Uterine Fibromas	[ ]	[ ]
13. Are You Using or Ever Used Hormone Replacement Therapy	[ ]	[ ]
14. Are You Currently Breastfeeding	[ ]	[ ]

NEXT PAGE

[*Next Page*]

FOOD Habits

Please briefly describe your usual eating habits that cover a typical week in your life.

Breakfast:

Lunch:

Dinner:

Snacks:

NEXT PAGE
[*Next Page*]

Health Check – Men's Symptom Review

Please review the symptom checklist below and indicate any symptoms you are experiencing

Symptom	None	Mild	Moderate	Severe	
Decreased Urine Flow					Estrogen Dominance
Increased Urinary Urge					
Prostate Problems					
Weight Gain – Chest / Hips					Metabolic Syndrome / Low Androgens
Weight Gain – Waist					
Decreased Libido					
Decreased Erections					
Ringing in Ears					
High Cholesterol					
Elevated Triglycerides					
Hot Flashes					
Night Sweats					
Decreased Mental Sharpness					
Increased Forgetfulness					
Decreased Muscle Size					
Decreased Flexibility					
Sore Muscles					
Increased Joint Pain					
Neck or Back Pain					
Bone Loss					
Rapid Aging					
Thinning Skin					
Decreased Stamina					
Burned Out Feeling					
Infertility Problems					
Stress					Adrenals
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Apathy					
Depressed					
Foggy Thinking					
Anxious					
Irritable					
Nervous					
Headaches					
Sugar Cravings					
Dizzy Spells					
Allergies					
Cold Body Temperature					Thyroid/ Other
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					

NEXT PAGE
[*Next Page*]

Health Check – Women's Symptom Review

Please review the symptom checklist below and indicate any symptoms you are experiencing

Symptom	None	Mild	Moderate	Severe	
Hot Flashes					Low Estrogen
Night Sweats					
Vaginal Dryness					
Incontinence					
Irregular Periods					Estrogen Dominant
Uterine Fibroids					
Water Retention					
Tender Breasts					
Fibrocystic Breasts					
Increased Forgetfulness					
Foggy Thinking					
Tearful					
Depressed					
Mood Swings					
Stress					Adrenals
Morning Fatigue					
Evening Fatigue					
Difficulty Sleeping					
Decreased Stamina					
Anxious					
Irritable					
Ringing in Ears					
Fibromyalgia					
Headaches					
Sugar Cravings					
Dizzy Spells					
Cold Body Temperature					Thyroid
Goiter					
Hoarseness					
Hair Dry or Brittle					
Nails Breaking or Brittle					
Constipation					
Slow Pulse Rate					
Rapid Heartbeat					
Heart Palpitations					
Infertility Problems					Metabolic Syndrome/High Androgen
Acne					
Increased Facial/Body Hair					
Scalp Hair Loss					
Weight Gain-Hips					
Weight Gain-Waist					
High Cholesterol					
Elevated Triglycerides					
Decreased Libido					Low Androgen / Other
Decreased Muscle Size					
Thinning Skin					
Aches & Pains					
Bone Loss					

NEXT PAGE

[*Next Page*]

Please provide any additional information that would help our medical staff evaluate your case.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Who referred you to our clinic:

[ ] Physician - Name: _____
[ ] Clinic – Name: _____
[ ] Another Patient at this Clinic
[ ] Coach / Trainer – Name: _____

Please return completed questionnaire to our office via e-mail (info@fitbodymd.me) or via FAX 813_938_7457

For more information, please visit our website : www.FiTbodymd.me