**NATIONAL TRT CLINICS**
Company Number: (615) 205-7756
695 President Place, suite 200, Smyrna
TN 37167
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# Medical History Form

## Personal Information

First Name | Last Name
Email | Enter Phone Number
Driver License #

### ADDRESS

Address 1 | Apt #
City | State
Zip | Country

### PHONE NUMBER

Primary Phone | Best Time To Call
Secondary Phone | Best Time To Call

### OTHERS

Occupation

## Medical History

### GENERAL

Enter Date Of Birth | Weight
Height | Gender ○ Male ○ Female

### PRIMARY PHYSICIAN INFORMATION

Physicians Name | Phone
Date Of Last Physical Exam | Last Colonoscopy Date

### OTHERS

Last Prostate Exam

### FAMILY HISTORY

Does an immediate family member currently have or ever had any of the following?

| | | | |
|---|---|---|---|
| Cardiovascular disease (heart attack, stroke, coronary artery bypass) | ○ Yes | ○ No | ○ N/A |
| Diabetes, thyroid or other Endocrine Disorder | ○ Yes | ○ No | ○ N/A |
| Hypertension | ○ Yes | ○ No | ○ N/A |
| High cholesterol/lipids | ○ Yes | ○ No | ○ N/A |
| Prostate cancer | ○ Yes | ○ No | ○ N/A |
| Other forms of cancer | ○ Yes | ○ No | ○ N/A |
| Other illnesses | ○ Yes | ○ No | ○ N/A |

If yes for other illnesses, please list them here

### LIFESTYLE INFORMATION

Do you smoke or use tobacco products? ○ Yes ○ No ○ N/A

If yes, on average, how much do you smoke or use tobacco per day?

How many years have you used tobacco?

Do you drink alcohol? ○ Yes ○ No ○ N/A

If yes, on average, how much do you drink per day or week?

How many years have you been drinking?

Do you take over the counter supplements? ○ Yes ○ No ○ N/A

If Yes, list Name and Quantity per day/week.

Do you exercise regularly? ○ Yes ○ No ○ N/A

If Yes, please describe.

Can you describe your diet? Please describe the foods you eat on a regular basis. Have you been following any certain diet guidelines such as the mediteranean diet, vegetarian, plant based diet, low carb, keto diet, orthe standard american diet (SAD) ?

### MEDICAL HISTORY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Any known deficiency including minerals and electrolytes | ○ Yes | ○ No | ○ N/A | Orthopedic or muscle disorder including fracture or joint disorders | ○ Yes | ○ No | ○ N/A |
| Use of medications (If , list medications below) | ○ Yes | ○ No | ○ N/A | Chemical Dependency | ○ Yes | ○ No | ○ N/A |
| Blood disorders | ○ Yes | ○ No | ○ N/A | Carpal Tunnel syndrome | ○ Yes | ○ No | ○ N/A |
| Auto-immune system disorder | ○ Yes | ○ No | ○ N/A | Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack | ○ Yes | ○ No | ○ N/A |
| Cancer | ○ Yes | ○ No | ○ N/A | Lung disorder | ○ Yes | ○ No | ○ N/A |
| Allergies to Medications | ○ Yes | ○ No | ○ N/A | Frequent upper respiratory infections | ○ Yes | ○ No | ○ N/A |
| Edema / excess fluid retention | ○ Yes | ○ No | ○ N/A | Poor wound healing | ○ Yes | ○ No | ○ N/A |
| Emotional disorders / depression | ○ Yes | ○ No | ○ N/A | Renal (kidney) disease | ○ Yes | ○ No | ○ N/A |
| Genital – Urinary disorder | ○ Yes | ○ No | ○ N/A | Hyperlipidemia | ○ Yes | ○ No | ○ N/A |
| Hypertension (High blood pressure) | ○ Yes | ○ No | ○ N/A | Neurological disorders | ○ Yes | ○ No | ○ N/A |
| Thyroid, Diabetes or other endocrine disorder including insulin resistance | ○ Yes | ○ No | ○ N/A | Arthritis | ○ Yes | ○ No | ○ N/A |
| Bursitis | ○ Yes | ○ No | ○ N/A | Rhuematoid arthritis | ○ Yes | ○ No | ○ N/A |
| Sports Injury(s) | ○ Yes | ○ No | ○ N/A | Heart attack (myocardial infarction) | ○ Yes | ○ No | ○ N/A |
| Stroke | ○ Yes | ○ No | ○ N/A | Other illnesses | ○ Yes | ○ No | ○ N/A |

Use the space below to explain the history of any above checked problems. Also please add any other health issues you might have that we didn't ask about

List all the medications you are taking.
Please be specific (Name, dosage, etc.) or specify "none":

Do you have any allergies to medications or foods? If yes, please list the substance and the reaction below:

Prior history of steroids or other hormones? ○ Yes ○ No ○ N/A

If yes, list type of medication, strength, dosage used, and dates of use (month and year) to your best memory

Type/Dose/Frequency :

### Do you currently have or have experienced any of the following symptoms?

If Yes, please check and explain below:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Increased lack of drive | ○ Yes | ○ No | ○ N/A | Depression | ○ Yes | ○ No | ○ N/A |
| Increasing fat deposits around the abdomen and/or thighs | ○ Yes | ○ No | ○ N/A | Difficulty sleeping | ○ Yes | ○ No | ○ N/A |
| Increasing mood swings | ○ Yes | ○ No | ○ N/A | Increasing wrinkles | ○ Yes | ○ No | ○ N/A |
| Progressive osteoporosis,decreasing bone density, or low trauma fractures | ○ Yes | ○ No | ○ N/A | Headaches / Migraines | ○ Yes | ○ No | ○ N/A |
| Increasingly stressed | ○ Yes | ○ No | ○ N/A | Loss of concentration,sociability, activity | ○ Yes | ○ No | ○ N/A |
| Hot flashes | ○ Yes | ○ No | ○ N/A | Decreased desire and ability to exercise | ○ Yes | ○ No | ○ N/A |
| Loss of interest in sex | ○ Yes | ○ No | ○ N/A | Decreased energy or endurance | ○ Yes | ○ No | ○ N/A |
| Muscle loss | ○ Yes | ○ No | ○ N/A | Sore Muscles, joint pain(s) or swelling | ○ Yes | ○ No | ○ N/A |
| Sagging, loose or thin skin | ○ Yes | ○ No | ○ N/A | Thinning or loss of hair | ○ Yes | ○ No | ○ N/A |
| Decreasing memory | ○ Yes | ○ No | ○ N/A | Decreasing size of testicles | ○ Yes | ○ No | ○ N/A |
| Decreasing muscle strength | ○ Yes | ○ No | ○ N/A | Weight loss – Unexplained | ○ Yes | ○ No | ○ N/A |
| Cold or heat intolerance | ○ Yes | ○ No | ○ N/A | Other | ○ Yes | ○ No | ○ N/A |

Please use this space to explain any additional information