

WELCOME TO AUSTIN LONGEVITY CENTER

Confidential Patient Information Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____
Phone (Home): _____ (Work): _____ (Mobile): _____
Email: _____ Referred By: _____
Age: _____ Birth Date: _____ Social Security No: _____ Sex: M / F Marital Status: S / M / W / D
Occupation: _____ Employer: _____
Spouse's Name: _____ Spouse's Work Phone: _____ Number of Children: _____
Emergency Contact: _____ Contact Phone: _____

Height: _____ Weight: Now _____ One Yr. Ago _____ Adult Max. _____ Age _____ Adult Min. _____ Age _____
Known Allergies: _____

Blood Type: _____ Have You Ever Had A Blood or Plasma Transfusion? Yes / No

Date of Last Physical Exam: _____ With Whom: _____ Where: _____
Reported Findings: _____
Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): _____

Fractures, Dislocations, Major Dental Work (List Year in Brackets): _____

Conditions You Have Had:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sinus Troubles |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/ Joint Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Numbness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Urinary Trouble |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parasites | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Yeast/ Candida |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> _____ |

Purpose of Appointment: _____

Other Doctors Seen For This Condition: _____

Have You Ever Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe): _____

Medications / Drugs You Are Taking (State Reason In Brackets Following Drug): _____

Insurance Information:

Who is responsible for this account? _____ Relationship To Patient: _____
Insurance Co: _____ Policy #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Whipple 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 also understand that any missed appointment without a 24-hour notice is subject to a fee. 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.

Responsible Party Signature Relationship Date

Habits:

Do You Smoke? Y/N What? _____ How Many / Day: _____ Since When? _____
 Other Tobacco Products? Y/N What? _____ How Many / Day: _____ Since When? _____
 Drink Coffee? Y/N Cups / Day _____ Drink Caffeinated Tea? Y/N Cups / Day _____
 Colas / Soft Drinks? Y/N Number / Day _____ Glasses of Water / Day: _____
 Alcoholic Beverages? Y/N Avg. No. / Wk _____ Mostly What? _____
 Do You Eat Red Meat? Y/N Are You A Vegetarian? Y/N If So, For How Long? _____
 Are You Dieting? Y/N If So, Describe: _____
 Do You Eat in Fast Food Restaurants? Y/N If So, How Many Times / Week _____
 List Nutritional Supplements You Take: _____
 Bowel Movement Frequency: _____ Difficulty? Y/N Approximate # of Times You Urinate/ Day: _____
 Do You Sleep Well? Y/N If No, Describe: _____ Average Hours / Night _____
 Do You Have Sufficient Energy For Normal Activities? Y/N If No, Describe: _____
 Do You Wear Corrective Lenses? Y/N What Is Your Uncorrected Vision? Right: _____ / 20 Left: _____ / 20
 Has Your Vision Changed Recently? Y/N Explain: _____
 Do You Wear Heel Lifts or Foot Supports? Y/N Explain: _____

Exercise:

What Sports Have You Played Seriously? _____
 What Sports Do You Enjoy Now? _____
 Are You In Training For a Particular Sport? Y/N Describe: _____
 Do You Use a Heart Rate Monitor? Y/N If So, Target Range: _____
 Describe Your Exercise Program: _____

XRAY HISTORY: (Include CAT, MIR, dye studies, and dental) When was most recent x-ray/other study? _____

Age	Body Area	Type (Normal X-ray, CAT, MRI, etc)	No. of Studies

FAMILY HISTORY: Please put (x) if no, leave blank

	Living	Age or Age At Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other, Description
Father													
Father's Mother													
Father's Father													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Siblings													
Your Siblings													
Your Children													

WOMEN ONLY: Menstrual History

Age at Onset: _____ Are Your Periods Regular? Y/N Cycle: _____ days (start to finish) Use Birth Control Pill? Y/N
 Your Flow Is: heavy medium light Date of Last Period: _____ Are You Pregnant? Y/N How many months _____
 Cramping? Y/N PMS? Y/N Other Menstrual / Hormonal Symptoms: _____
 Vaginal Infections? Y/N Miscarriage? Y/N