



**NOBLE CENTER
FOR HEALTHY AGING**

2499 Glades Road, Suite 305A Boca Raton, FL 3343

Ph:561.392.3788 Fax:561.392.3785

www.noblehealthyaging.com

General Information:

PATIENT LAST NAME: _____ FIRST NAME: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE(CELL): _____ PHONE(HM): _____ AGE: _____ D.O.B.: _____ SEX: _____

Marital Status: M / S /D NO. CHILDREN: _____ SS# _____ - _____ - _____ OCCUPATION: _____

OUT OF STATE ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT: _____ EMERGENCY CONTACT PHONE: _____

WHO MAY WE THANK FOR REFERRING YOU TO NOBLE CENTER: _____

This Section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Please check appropriate box(s):

African-American Hispanic Mediterranean Asian

Native American Caucasian Northern European Other

Place of Birth: _____ (city and state; provide country if outside U.S.)

Allergies: _____

Reason for Consultation

What health concerns and symptoms bring you to our clinic? _____

NOBLE CENTER FOR HEALTHY AGING: PATIENT HISTORY FORM

DATE: _____

Please complete this form to the best of your ability. The doctor will review your answers during your visit.

LAST NAME: _____ FIRST NAME: _____ MIDDLE : _____ D.O.B.: _____

PRIMARY CARE DOCTOR: _____ OFFICE NUMBER: _____ DATE OF LAST PHYSICAL EXAM: _____

HEIGHT: _____ WEIGHT: _____ For Weight Loss Patients: GOAL WEIGHT _____ LOWEST ADULT WEIGHT _____

MEDICAL & FAMILY HISTORY	Self	Family		Self	Family		Self	Family
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Loss of Consciousness			Pulmonary Hypertension			Gallbladder		
Stroke			Chronic Bronchitis			disease/stones		
Glaucoma			Shortness of Breath			Ulcers		
Thyroid Disorder			Irregular Heart Beat			Colitis		
Obesity/Overweight			Heart Attack or Angina			Constipation		
Diabetes Mellitus (DM)			Palpitations			Arthritis		
High Blood Sugar			Heart Valve disorder			Gout		
Abn. Cholesterol			Heart Failure(CHF)			Osteopenia or Osteoporosis		
Insomnia			High Blood Pressure			Kidney Disease or stones		
Dementia			Rheumatic Fever			Excessive Stress		
Psoriasis/Eczema			Tuberculosis			Alcohol Abuse		
Bleeding disorder			Hiv			Drug Abuse		
Menstrual Disorder			Cancer (type:)			Depression or Anxiety		
Reproductive Problems			Back Pain/ Sciatica			Eating Disorder		
Recurrent Sinus Infections			Fibromyalgia			Other Psychiatric Illness		
Seasonal Allergies			Neck Pain			Sexual/Libido Problems		
Thyroid Disease			Carpal Tunnel Syndrome			Artificial Joint/Implants		

Doctor Notes:

Surgeries & Hospitalizations:

<i>Reason/Diagnosis</i>	<i>Year</i>

Specialist Names (If Any):

What medications are you taking now? Include nonprescription drugs.

<i>MEDICATION NAME</i>	<i>DATE STARTED</i>	<i>DOSAGE</i>

Are you allergic to any medications? Yes No

If yes, please list: _____

List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

SUPPLEMENT	DATE STARTED	DOSAGE

Nutritional supplements, vitamins, herbs, and homeopathic remedies taken:

Screening:

TEST	Last date done	Results (-) or state findings
Blood Sugar, Cholesterol		
Colonoscopy		
PAP Smear (woman)		
Mammogram (woman)		
Prostate exam, PSA (men)		
Cardiac test (EKG,echo,stress, etc.)		
Transvaginal Ultrasound		

How often have you have taken antibiotics? _____

Please

explain: _____

How often have you have taken oral steroids (e.g., cortisone, prednisone, etc.)? _____

Please

Explain: _____

FEMALE patients: Please check all that apply

<i>Symptoms</i>	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
<i>Sleep Disorder</i>				
<i>Anxiety/Nervousness</i>				
<i>Irritability</i>				
<i>Depression</i>				
<i>Food Cravings</i>				
<i>Weight gain</i>				
<i>Hot Flashes</i>				
<i>Night Sweats</i>				
<i>Vaginal Dryness</i>				
<i>Urine Leakage</i>				
<i>Dry Skin/Wrinkles</i>				
<i>Dry Hair</i>				
<i>Fatigue</i>				
<i>Memory Loss</i>				
<i>Concentration Loss</i>				
<i>Hair loss</i>				
<i>Loss of Libido/Orgasim</i>				
<i>Muscle Weakness</i>				
<i>Muscle and Joint Pain</i>				
<i>Breast tenderness</i>				
<i>Loss of pubic hair</i>				

MALE patients: Please check all that apply

<i>Symptoms</i>	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
<i>Sleep Disorder</i>				
<i>Anxiety/Nervousness</i>				
<i>Irritability</i>				
<i>Depression</i>				
<i>Dry Skin</i>				
<i>Dry Hair</i>				
<i>Difficulty maintaining erection</i>				
<i>Difficulty achieving erection</i>				
<i>Do you wake up in the morning with an erection?</i>				
<i>Premature ejaculation</i>				
<i>Fatigue</i>				
<i>Memory Loss</i>				
<i>Concentration Loss</i>				
<i>Hair loss</i>				
<i>Loss of Libido/Orgasim</i>				
<i>Muscle Weakness</i>				
<i>Muscle and Joint Pain</i>				
<i>Loss of masculinity/confidence/aggressiveness</i>				

OB/GYN HISTORY (Female Patients)

Age at first onset of period: _____ First day of last menstrual cycle: _____

If still menstruating: cycle _____ days Circle if (+): Heavy Periods, Irregularity, Spotting or pain

Do you perform monthly self breast exams yes no

Are you pregnant? yes no Are you breastfeeding? yes no

Are you trying to get pregnant? yes no

Number of pregnancies: _____ Living children _____ (Vaginal _____ C-section _____) Abortions _____ Miscarriages _____

Any history of sexual abuse? _____

Are you currently taking or have you in the past taken hormones or oral contraceptives yes no

If yes, please list all hormones and oral contraceptives you have taken and when _____

Have you had a hysterectomy? yes no If yes, were your ovaries removed? yes no

Has your abdominal girth and weight been increasing? yes no

PERSONAL & SOCIAL HISTORY:

Occupation: _____ Stress level (0-10): _____

Marital Status: _____ Do you feel safe in your relationship? yes no

Use of Alcohol: yes no If YES, what kind: _____ How many drinks/week: _____

Tobacco: yes no If YES, number of years total: _____ Past use-quit date: _____

Recreational or Street Drugs: yes no If YES, have you ever taken street drugs with a needle? yes no

Sexually Active: yes no
Heterosexual
Bisexual
Homosexual

Contraception:
Current method: _____

Hobbies/Interests: _____

Review of Symptoms:

Please check YES to any symptoms that you experience. For any YES answer please provide a brief description.

Symptoms	YES	If YES, list Doctor seen, describe condition and how long
Fever/Chills		
Excess Fatigue		
Weight loss/Gain		
Enlarged Lymph nodes		
Frequent Bruising		
Blurry Vision		
Ringing in Ears		
Hearing Difficulty		
Mouth Sores		
Sinus Problems		
Cardiovascular:		
Chest Pain at rest or exercise		
Cold hands/feet		
Swelling of legs		# bowel movement/day _____
Gastrointestinal		
Constipation		
Diarrhea		
Bloating		
Excessive bleching		
Gas/acidity		
Blood in stool		
Thirst: Lack of/too much		# glasses of fluid/day _____
Genitourinary		
Pain on urination		
Cloudy/bloody Urination		
Urinating too many times		# times per day _____
Difficulty urinating		
Loss of urine		
Musculoskeletal:		
Do you see a Chiropractor?		
Any regular body treatment/massage?		
Back Pain		
Neck Pain		
Shoulder Pain		
Arm Pain		
Hip Pain		
Knee Pain		
Other Pain		
Muscle point tenderness (pls.describe)		
Skin		
Acne		
Dry Skin		
Oily Skin		
Loss of collagen/Firmness		
Wrinkles		
Pigmentation/Scarring		
Any history of skin cancer?		
Do you wear sunblock?		
Cellulite		
Emotional		
Do you see a counselor or psychiatrist?		
Depression		
Anxiety		
Stress		

I have answered the above questions to the best of my abilities:

Patient Signature: _____ Date: _____



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Nutritional Evaluation:

Vegetable Intake: (pls. circle):	<10%	20-40%	41-60%	>60%
Number of meals per day:				
Snacks per day:		What snacks and when?		
Food Allergies?				
Food Dislikes:				
Food(s) you crave:		Any specific time of day/month you crave food?		
Do you awaken hungry during the night?		<input type="radio"/> yes <input type="radio"/> no	If so, what do you do?	
Behavior Style:				
_____ Always calm & easygoing		_____ Seldom calm and persistently driving for advancement		
_____ Usually calm & easygoing		_____ Never calm and have overwhelming ambition		
_____ Sometimes calm with frequent impatience		_____ Hard-driving and can never relax		

	NO	YES		NO	YES
Partner of spouse overweight? By how much _____ LBS.			I cook my meals		
I eat out daily			I shop for food		
I eat out _____ times/week			I use shopping list for grocery		
I eat "fast foods" daily			Time of day I usually food shop:		
I eat fast foods _____ times/week			I use sugar substitute		
I drink cola drinks			I use butter		
I eat when I'm stressed			I use margarine		
I am currently stressed.			I drink coffee or tea How many cups/day: _____		
I skip meals			I eat on behalf of someone else.		
I plan my meals					

If Weight Loss is an aim for you, please answer the following questions.

Goal Weight: _____ **In what time frame would you like to be at your goal weight?** _____

Birth Weight: _____ **Weight one year ago:** _____ **Heighest weight (non-pregnant) and when:** _____

Lowest adult weight(>age18): _____

Main reason for your decision to lose weight:

When did you begin gaining excess weight? (Give reasons, if known):

Previous diets followed:

What is a typical breakfast for you:

Time eaten: _____ **Where:** _____ **With whom:** _____

What is a typical lunch for you:

Time eaten: _____ **Where:** _____ **With whom:** _____

What is a typical dinner like for you:

Time eaten: _____ **Where:** _____ **With whom:** _____

Activity Level:

- Inactive:** no regular physical activity with a sit-down job.
- Light activity:** no organized physical activity during leisure time.
- Moderate activity:** occasionally involved in activities such as weekend golf, tennis, jogging, swimming, or cycling.
- Heavy activity:** consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling, or active sports at least three times per week.
- Vigorous activity:** participation in extensive physical exercise for at least 60 minutes per session less than or equal to 4 times per week.
- Stretch/Yoga/Tai Chi/Chi Gong*

Please describe your general health goals and improvements you wish to make:

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Patient Signature: _____ **Date:** _____