TOTAL VITALITY
Medicina Anti-aging
Medicina Estética
Odontología

DATE: _____

FIRST NAME | LAST NAME (S)

DATE OF BIRTH | PHONE NUMBER | CELL PHONE NUMBER

OCCUPATION | PLACE OF WORK

HOME ADDRESS

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR YOUR MEDICAL CONSULTATION.

PART 1. HEREDITARY FAMILY BACKGROUND.

Please mark with an “X” if any family member has had any of the following illnesses. In affirmative cases, in the space beside it, also indicate with an “X” how you are related (whether it is your father, mother, sibling, parent’s sibling, grandparent).

ILLNESS	FATHER	MOTHER	SIBLING	PARENT'S SIBLING	GRANDFATHER	GRANDMOTHER
High blood pressure						
Low blood pressure						
Diabetes mellitus						
Asthma						
Allergies						
Cancer						
Alzheimer’s disease						
Dementia						
Parkinson’s disease						
Epilepsy						
Psychiatric illness						

OTHER ILLNESSES: _____

PART II. NON-HEREDITARY PERSONAL BACKGROUND.

Please fill in the following spaces with your personal information:

TABACCO SMOKING

- ☐ NO
- ☐ YES
- ☐ SMOKED IN THE PAST

HOW MANY CIGARETTES PER DAY OR HOW OFTEN DO YOU SMOKE? _____

HOW LONG AGO DID YOU QUIT? _____

ALCOHOL DRINKING

- ☐ NO
- ☐ YES
- ☐ OCASIONALLY

WHAT KIND OF ALCOHOL DO YOU LIKE TO DRINK? _____

WHY DON'T YOU DRINK ALCOHOL? _____

HOW OFTEN DO YOU DRINK ALCOHOL? _____

HOW MUCH DO YOU THINK YOU CAN DRINK WITHOUT IT CAUSING SECONDARY EFFECTS THE DAY AFTER DRINKING? _____

IF YOU HAVE SECONDARY EFFECTS THE DAY AFTER DRINKING ALCOHOL (BUT WITHOUT OVERDRINKING), WHAT ARE THEY?

_____

DRUGS

- ☐ NO
- ☐ YES

WHICH ONE(S)? _____

HOW OFTEN? _____

DO YOU HAVE ALLERGIES?

- ☐ NO
- ☐ YES

SPECIFY: _____

DO YOU HAVE KNOWN ALLERGIES TO MEDICATIONS? ☐ NO ☐ YES

SPECIFY: _____

EMPLOYMENT INFORMATION

OCCUPATION _____

EMPLOYER: _____

DOES YOUR JOB CAUSE STRESS? ☐ NO ☐ YES

DO YOU OVERSEE OTHER EMPLOYEES? ☐ NO ☐ YES HOW MANY?: _____

DO OTHER EMPLOYEES OVERSEE YOU? ☐ NO ☐ YES HOW MANY? ☐

IS YOUR EMPLOYER A FAMILY BUSINESS? ☐ NO ☐ YES

IS YOUR BOSS A FAMILY MEMBER? ☐ NO ☐ YES SPECIFY RELATIONSHIP: _____

INFORMATION REGARDING HOME LIFE

WITH WHOM DO YOU LIVE? _____

DO YOU HAVE A PARTNER/SPOUSE? ☐ NO ☐ YES AGE OF PARTNER/SPOUSE: _____

DO YOU HAVE CHILDREN? ☐ NO ☐ YES HOW MANY?: _____ AGE (S) CHILDREN _____

DO YOU HAVE DOGS? ☐ NO ☐ YES HOW MANY?: _____

DO YOU HAVE CATS? ☐ NO ☐ YES HOW MANY?: _____

DO YOU HAVE OTHER PETS? ☐ NO ☐ YES WHAT KIND (S)? _____

INFORMATION REGARDING DAILY HABITS

IN GENERAL, WHAT TIME DO YOU GO TO BED? _____

WHAT TIME DO YOU LIKE TO/THINK IS THE PERFECT TIME TO GO TO BED? _____

DO YOU DREAM WHILE ASLEEP? ☐ NO ☐ YES

HOW MANY DREAMS DO YOU HAVE PER WEEK? _____

ARE THERE COLORS IN YOUR DREAMS? ARE THEY BRIGHT COLORS? ☐ NO ☐ YES

ARE THEY PASTELS OR BLACK AND WHITE? ☐ NO ☐ YES

DO YOU HAVE EROTIC DREAMS? ☐ NO ☐ YES

HOW MANY EROTIC DREAMS DO YOU HAVE PER MONTH OR HOW OFTEN? _____

DO YOU GET UP BEFORE DAWN TO URINATE? ☐ NO ☐ YES

WHAT TIME? _____

ARE YOU ABLE TO FALL BACK ASLEEP? ☐ NO ☐ YES

WHAT TIME DO YOU GET UP IN THE MORNING? _____

WHAT TIME DO YOU GET UP DURING VACATIONS OR ON SUNDAYS? _____

DO YOU HAVE BACK AND/OR NECK PAIN IN THE MORNING? ☐ NO ☐ YES

IN THE MORNING, DO YOU HAVE ALLERGIES, COUGH, SNOT, RHINITIS? ☐ NO ☐ YES

HOW MANY YEARS OF USE DOES YOUR MATTRESS HAVE? _____

HOW MANY YEARS HAVE YOU HAD YOUR PILLOWS? _____

WHICH DO YOU PREFER: ☐ SAVORY FOOD ☐ SWEET FOOD

HOW MUCH PURE WATER DO YOU DRINK PER DAY? _____

HOW MANY TIMES DO YOU URINATE PER DAY? _____

DO YOU HAVE CONSTIPATION OR BOWEL MOVEMENT ISSUES? ☐ NO ☐ YES ☐ OCCASIONALLY

HOW OFTEN DO YOU HAVE A BOWEL MOVEMENT? _____

HOW IS THE STOOL/BM?: ☐ HARD ☐ PAINTFUL ☐ BALL-SHAPED ☐ NORMAL

HOW IS YOUR MEMORY? ☐ VERY GOOD ☐ GOOD ☐ POOR ☐ VERY POOR

HOW IS YOUR ABILITY TO LEARN? ☐ VERY GOOD ☐ GOOD ☐ POOR ☐ VERY POOR

WHEN DO YOU HAVE THE MOST ENERGY? ☐ MORNING ☐ AFTERNOON ☐ EVENING

WHEN ARE YOU THE MOST ALERT? ☐ MORNING ☐ AFTERNOON ☐ EVENING

PART III. PERSONAL MEDICAL BACKGROUND

DO YOU TAKE MEDICATIONS? ☐ YES ☐ NO WHICH ONE (S)? _____

SPECIFY THE DOSAGE(S) YOU TAKE: _____

TIME(S) WHEN YOU TAKE THEM: _____

DO YOU TAKE THEM BEFORE EATING BREAKFAST? ☐ YES ☐ NO

DO YOU TAKE VITAMINS? ☐ YES ☐ NO WHICH ONE (S)? _____

SPECIFY THE DOSAGE(S) YOU TAKE: _____

TIME(S) WHEN YOU TAKE THEM? _____

PART IV. SURGICAL BACKGROUND

HAVE YOU HAD SURGERIES? ☐ YES ☐ NO

SPECIFY WHICH SURGERIES AND WHAT AGE YOU WERE: _____

PART V. OB-GYN BACKGROUND (WOMEN ONLY)

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUATION? _____

AT WHAT AGE DID YOU GROW ARM PIT HAIR AND DEVELOP BODY ODOR? _____

_____

HOW OLD WERE YOU WHEN YOU GREW PUBIC HAIR? _____

AT WHAT AGE DID YOUR BREASTS DEVELOP? _____

DATE OF LAST MENSTRUATION: _____

HOW LONG DOES (OR DID) YOUR MENSTRUAL CYCLE LAST?

☐ 21-28 DAYS ☐ 28-35 DAYS

HOW MANY DAYS DID YOU BLEED? _____

WHICH DAY WAS THE BLEEDING HEAVIEST? _____

MENSTRUAL PAIN? ☐ WEAK ☐ STRONG ☐ VERY STRONG

IF YOU HAVE PAIN, HOW OFTEN?: ☐ MONTHLY ☐ ALTERNATELY (ONE MONTH YES BUT NOT THE NEXT)

DO YOU EXPERIENCE WATER RETENTION IN YOUR BREASTS, BREAST PAIN OR BREAST TENDERNESS DURING YOUR MENSTRUAL CYCLE? ☐ YES ☐ NO

DURING WHICH PART OF THE MONTH? _____

DO YOU EXPERIENCE WATER RETENTION, HEAVINESS OR CRAMPING IN YOUR LEGS DURING YOUR MENSTRUAL CYCLE? ☐ YES ☐ NO

DURING WHICH PART OF THE MONTH? _____

DO YOU HAVE ENDOMETRIOSIS (ENDOMETRIUM FORMS OUTSIDE UTERUS)? ☐ YES ☐ NO

WHAT DEGREE OF ENDOMETRIOSIS DO YOU HAVE? ☐ SLIGHT ☐ SEVERE ☐ VERY SEVERE

DO YOU HAVE UTERINE FIBROIDS OR ANY OTHER UTERINE TUMORS? ☐ YES ☐ NO

DO YOU HAVE POLYCYSTIC OVARY SYNDROME? ☐ YES ☐ NO

DO YOU HAVE FIBROCYSTIC BREAST DISEASE (ADENOMAS, FIBROIDS OR FIBROADENOMAS IN THE BREAST)? ☐ YES ☐ NO

DO YOU EXPERIENCE CHANGES IN HUMOR DURING YOUR MENSTRUAL CYCLE?

☐ CRYING ☐ ANGER ☐ SADNESS ☐ ALL THREE ☐ NONE

DATE OF LAST PAP SMEAR: _____

DATE OF LAST MAMMOGRAM: _____

DATE OF LAST BREAST ULTRASOUND: _____

DATE OF LAST BONE DENSITY TEST: _____

HOW IS YOUR LIBIDO OR SEX DRIVE? ☐ LOW ☐ NORMAL ☐ HIGHT

DO YOU PREFER TO SLEEP RATHER THAN HAVE SEXUAL INTERCOURSE? ☐ YES ☐ NO

DO YOU EASILY REACH AN ORGASM? ☐ YES ☐ NO

DO YOU EXPERIENCE VAGINAL DRYNESS OR OTHER ISSUES DURING SEX? ☐ YES ☐ NO