

The Genetic Institute of Anti Aging

Patient History Form

Patient Name _____ Date _____

Height _____ Weight _____ Date of Birth _____

Please fill out as completely as possible. This is a confidential record of your medical history and will be kept in your chart. No information will be released without your permission.

Medical History: If you currently have or have had any of the following, please mark with an X

<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemic
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Anemia	<input type="checkbox"/> Angina	<input type="checkbox"/> Venereal Disease	
<input type="checkbox"/> Jaundice	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Measles	
<input type="checkbox"/> Depression	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Chicken Pox	
<input type="checkbox"/> Nervous Breakdown	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Typhoid	<input type="checkbox"/> Cancer	

NEUROMUSCULAR

Seizures
 Loss of Consciousness
 Joint Disorder
 Numbness
 Paralysis
 Pain

GYNECOLOGY

Pregnancy
 # of Live Births
 # of Miscarriages
 Menses-Regular
 Menses-Irregular
 Breast Discharge

GASTROINTESTINAL

Nausea
 Lack of Appetite
 Difficulty Swallowing
 Chronic Indigestion
 Black Stool
 Ulcer History
 Hemorrhoids

CARDIOVASCULAR

Chest Pain
 Shortness of Breath
 Palpitations
 Mitral Valve Prolapse
 Irregular Heartbeat
 Bleeding Tendencies
 Blood Clots

HEAD

Headaches
 Dizziness
 Tremors
 Fainting

EENT

Hearing Impaired
 Double Vision
 Poor Vision
 Nasal Obstruction
 Sinus Infection
 Post Nasal Drip

RESPIRATORY

Chronic Cough
 Bloody Sputum
 Night Sweats
 Asthma/Wheezing
 Sleep Apnea
 Weight Loss

URINARY

Blood in Urine
 Discharge
 Difficulty Urinating

ARE YOU ALLERGIC TO LATEX RUBBER? YES NO

ARE YOU ALLERGIC TO ANY DRUGS? YES NO

If yes, please list _____

ARE YOU TAKING ANY DRUGS, HERBS OR VITAMINS? YES NO

If Yes, List name and dosage _____

DO YOU HAVE A HISTORY OF CANCER IN YOUR FAMILY? YES NO

If Yes, List type of cancer and family relationship _____

PREVIOUS OPERATIONS (Provide year and type of operation) YES NO

HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA? YES NO

If yes, please describe _____

AMOUNT OF CONSUMPTION OF _____ ALCOHOL _____ TOBACCO _____ CAFFEINE

RECENT EMAMINATIONS

PHYSICAL YES NO Date _____

CHEST X-RAY YES NO Date _____

LAB WORK YES NO Date _____

Signature _____ Date _____

Genetic Institute of Anti-Aging (GIAA)

South Coast Metro, 720 Paularino Ave, Suite 200
 Costa Mesa, CA 92626

Email: info@getyournewlook.com

Toll Free: 1-800-639-5665 | Phone: (714) 641-2640 | Fax: (714) 641-2646