PRC Rejuvenation Center

Name (print):_____ Gender: Male / Female Date _____

Mailing Address:_____City:_____State:_____Zip:_____

DOB:_____ Cell Phone: _____Marital Status:_____

Social Security No:_____ Employer:_____

Due to medical guidelines, PRC Rejuvenation Center is required to obtain a printed copy of a current driver's license and/or other state *issued photo ID for proper verification of identity prior to receiving any medical procedures.*

Email Address: _____

Any Known Allergies: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Pharmacy and Location: _____

Phone:_____ Fax:_____

List primary reason for visit:

_____

List all Medications and Herbal Supplements that you are currently taking:

Prescription/Supplement: Dosage (eg. Mg/pill): How many times per day?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you currently taking any supplements for Hormonal Imbalance or Replacement? Yes / No

If yes, please be sure to list above and describe the method: Oral, Cream, Injection and/or Pellet Therapy

How did you hear about us?_____

Signature_____Date:_____

In following within medical guidelines and state requirements, every new client is required to have a Face to Face with our medical director prior to any medical procedures. PRC Rejuvenation Center follows all medical guidelines for your safety and protection.

*Please give 24 hour cancellation notice for any rescheduled appointments. PRC Rejuvenation Center reserves the right to request payment prior to service and to bill accordingly for treatments therefore received. Any additional treatments followed after a package deal is the financial responsibility of the client and/or guardian, if under 18 years of age. A 10% service fee will be charged on all returns and/or refunds. All sales on services performed are final and non-negotiable.

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History and Physical

Name (Please Print): _____ **DOB:** _____

Are you currently under medical treatment YES / NO

Please describe:

_____

Please individually check each condition you currently have or have had in the past:

Cardiovascular
- ◯Syncope/Fainting *R55*
- ◯Palpitations *R00.2*
- ◯Chest Pain *R07.9*
- ◯Fluid retention *R60.9*
- ◯Abnormal blood sugar *R73.09*
- ◯Varicose veins *R183.90*
- ◯Elevated blood-pressure *R03.03*

Gastrointestinal
- ◯Abdominal Pain *R10.9*
- ◯Pelvic Pain *R10.2*
- ◯Nausea *R11.0*
- ◯Heartburn *R12*
- ◯Bloating *R14.0*
- ◯Change in bowel habit *R19.4*
- ◯Constipation *K59.0*

Family History
- ◯Heart Disease *Z82.49*
- ◯Stroke *Z82.3*
- ◯Diabetes mellitus *Z83.3*
- ◯Osteoporosis *Z82.62*
- ◯Alzheimer's *Z82.0*
- ◯Dementia *Z81.8*
- ◯Cancer *Z80.0*

Substance Use
- ◯Smoker/Tobacco Use
- ◯Alcohol Use *F10.99*

Medication Use
- ◯Long term drug therapy *Z79.899*
- ◯Long term use of aspirin *Z79.82*
- ◯L/T use of hormones *Z79.891*
- ◯Blood pressure med *Z79.899*
- ◯Cholesterol med *Z79.899*

Cardiac History
- ◯DVT *I80.299*
- ◯PVD *I73.9*
- ◯Primary hypertension *I10*
- ◯Myocardial infarction *I25.2*
- ◯Heart disease *I51.9*
- ◯Atherosclerosis *I70.90*
- ◯Atrial fibrillation *I48.91*
- ◯Cardiac arrhythmia *I49.9*
- ◯Diarrhea *R19.7*
- ◯Urgency of urination *R39.15*
- ◯Obesity *E66.0*
- ◯Overweight *E66.3*

Constitutional
- ◯Excessive sweating *R61*
- ◯Fever *R50.9*
- ◯Chills R68.83
- ◯Drowsiness *R40.0*
- ◯Weakness *R53.1*
- ◯Abnormal weight loss *R63.4*
- ◯Abnormal weight gain *R63.5*
- ◯ Excessive thirst *R63.1*
- ◯ Excessive eating *R63.2*

Respiratory
- ◯Sinusitis *J32.9*
- ◯Asthma *J45.909*
- ◯Cough *R05*
- ◯Shortness of Breath *R06.02*
- ◯Snoring *R06.83*
- ◯Painful respiration *R07.1*
- ◯Wheezing *R06.2*

Neurology
- ◯Paresthesia/numbness *R20.2*
- ◯Lack of coordination *R27.9*
- ◯Headache *R51*
- ◯Migraine *G43.909*
- ◯Pulmonary embolism *I26.99*
- ◯Hyperlipidemia *E78.5*
- ◯Anxiety *F41.9*
- ◯Depression *F33.1*
- ◯Insomnia *G47.00*
- ◯Memory loss *R41.3*
- ◯Disorientation *R41.0*

Endocrine History
- ◯ Type 2 Diabetes *E11.9*
- ◯ Type 1 Diabetes *E10.9*
- ◯ Pre- Diabetes *R73.01*
- ◯Autoimmune thyroiditis *E06.3*
- ◯Thyroid disorder *E07.9*
- ◯Hypothyroidism *E03.9*
- ◯Hyperthyroidism *E05.9*

Metabolic History
- ◯Vit B deficiency *E55.9*
- ◯Metabolic syndrome *E88.81*
- ◯Chronic renal disease *N18.9*
- ◯Anemia *D64.9*
- ◯Sickle-cell trait *D57.3*
- ◯Systemic lupus *L40.9*

Neurological History
- ◯PTSD *F43.10*
- ◯Cerebrovascular disease *I67.89*
- ◯Stroke *I63.9*
- ◯TIA *G45.9*
- ◯Alzheimer's disease *G30.9*
- ◯Dementia *F03.91*
- ◯Parkinson's disease *G20*
- ◯Concussion *F07.81*

Patient Signature: _____ **Date:**_____

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Respiratory History
◯COPD *J44.9*
◯Emphysema *J43.9*
◯Repeated Falls *R29.6*

◯Disorientation *R41.0*
◯Vertigo *R42*
◯Insomnia *G47.00*
◯Obstructive sleep apnea *G47.33*

Muscle/Skeletal
◯Chronic Pain *G89.29*
◯Leg Pain *M79.609*
◯Back Pain *M54.89*

◯Joint Pain *M25.50*
◯Chronic fatigue *R52.85*
◯Tiredness *R53.85*
◯Cramps and spasms *R25.2*
◯Restless leg syndrome *G25.81*

Gynecology (women only)
◯Hot Flashes *N95.9*
◯Heavy menses *N93.8*
◯Menstrual irregularities *N92.6*

◯Fibrocystic breast *N65.9*
◯Tender breast *N64.9*
◯Cystic ovaries *N89.20*

Musculoskeletal History
◯Osteoporosis *M81.8*
◯Osteoarthritis *M15.9*
◯Gout *M10.9*

Gastrointestinal History
◯Esophageal reflux *K21.9*
◯Gastritis *K29.70*
◯H. Pylori *B96.81*
◯Irritable bowel syndrome *K58.9*
◯Celiac disease *K90.0*
◯ Crohns' disease *K50.90*
◯Ulcerative colitis *K51.9*
◯Liver disease *K76.9*
◯Steatosis/ fatty liver *K76.0*
◯Diverticulosis *K57.30*

Have you had any suspicious moles, lumps, masses or fibrous tissues removed? Yes or No?_____ If yes please explain

_____

_____

Continued…

WOMEN ONLY
Do you have regular periods? YES / NO
Age of 1st menstrual cycle: _____
Last menstrual cycle: _____
Are you currently pregnant or could be pregnant? YES / NO
Have you ever been pregnant? YES / NO
Number of pregnancies_____
Do you currently have an IUD or take birth control pills YES / NO
Have you ever had a ***(please check):*** YES / NO
◯Tubal ligation ◯ Ablation or hysterectomy (Partial or Total)

Patient Signature: _____ **Date:**_____

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Have you ever had any serious illness or operations? YES/NO

Please check all that apply:

◯ Angioplasty ◯ Back surgery ◯ Gall Bladder ◯ Hip replacement ◯ Broken Bone Repair
◯ Heart stent ◯ Open-heart surgery ◯ Colon resection ◯ Knee replacement ◯ Pacemaker
◯ Appendectomy ◯ Carpal Tunnel ◯ Colostomy ◯ LASIK ◯ Thyroidectomy
◯ Knee scope ◯ Cataract Surgery ◯ Gastric bypass ◯ Liver biopsy ◯ Tonsillectomy
◯ Prostate Biopsy ◯ TURP ◯ Vasectomy ◯ Breast Biopsy ◯ Breast Augmentation
◯ Cesarean section ◯ Mastectomy ◯ Myomectomy ◯ Small Bowel Rest. ◯ Breast Reduction
◯ Hernia repair: _____ ◯ other: _____

Have you had any allergic reactions to the following:

◯ Local Anesthetics (e.g. Novocain) ◯ Penicillin ◯Sulfa ◯Other antibiotics: _____

Family History:

Diagnosis	Family member(s)	Age at onset	Living?
ADD/ADHD			
Alcoholism			
Allergies			
Alzheimer's Disease			
Asthma			
Blood Disease			
Heart Disease			
Cancer:			
Stroke			
Depression			
Developmental delay			
Diabetes			
Eczema			
Hearing deficiency			
Elevated Cholesterol			
High blood pressure			
Obesity			

Diagnosis	Family member(s)	Age at onset	Living?
Irritable Bowel Disease			
Mental illness			
Migraines			
Osteoartritis			
Osteoporosis			
Peripheral vascular disease			

Per the recommendation of PRC Rejuvenations' Nurse Practitioner I consent to having the following test performed if I qualify for them.

- ANS (Pulmonary Cardiovascular Testing)
- Neuro Scan (Neurology Scan)
- PGX (Medication Screening- Mouth Swab)
- CGX (Cancer Screening- Mouth Swab)

Patient Signature: _____ **Date:**_____

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CONSENT FOR RELEASE OF MEDICAL RECORDS

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy of this release or a fax of this release shall be as valid as this original release. Please send copies of all requested information as soon as possible to the address listed below:

Patient's Name _____
Patient's Address _____
Patient's Date of Birth _____
Patient's Social Security Number _____

Please release my medical records from (Name, Address, Phone Number, Fax Number):

_____
_____
_____

Please send my medical records to (Name, Address, Phone Number, Fax Number):

_____
_____
_____

Any cost incurred with this request will be patient's responsibility.
This agreement will become void with my written consent deeming otherwise.

Patient's Signature: _____ Date:_____

Parent/Guardian (If a minor) _____ Date: _____

Witness:_____