Renew Wellness and Regenerative Medicine
528 48th St Ct E
Bradenton, FL 34208

Today's Date: ________________

Office Use ONLY		
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Health Assessment

First Name: __________________________ Last Name: ________________________________
Address: ____
City: _________________________________ State: _________ Zip Code: ____________
Phone (Cell): ____________________ Phone (Home/Work): ___________________
Date of Birth: ___/___/_____ Age: __________ Sex: ____________ Race: __________
Email Address (Please Print) ____
Current Height: ______________ Weight: __________Weight 1 Year Ago: __________
Lowest Adult Weight: _________ At what Age? _______ How long maintained? _______
Lowest Adult Weight Maintained for > 1 year____________ At what age? ______________
What is your personal goal weight this time? ___________lbs

How many times have you intentionally lost 20lbs or more and gained it all back?
Never ____ Once or twice _____ 3-4 Times _____ 5+ Times _____

*Have you ever been Diagnosed with an Eating Disorder? Yes or NoIf Yes, what type? ___________

Do you exercise? Yes or No Frequency per week? __________Hrs or mins per session___________
How long have you been exercising? __________ What type of exercise do you do? ______________

Check all that Apply:

☐ I eat when I am not hungry.	☐ I can over eat almost any food.
☐ I sometime eat much faster and/or much more than others.	☐ I graze or snack frequently between meals
☐ I isolate from others so I can eat the way I want.	☐ I am obsessive about the way I think about food.
☐ I sometimes think I will Eat moderately and then eat much more than I expected to eat.	☐ I think weight causes me serious physical and social problems and I still overeat
☐ I use food to numb difficult feelings	☐ I have tried to stop bingeing and been unable to stay stopped

Medical Diagnosis: (Have you ever been Diagnosed with Anything?)

Year	Reason

List All Current Medications and Supplements Including Name, Frequency, and Dose (Include hormones and birth control pills.)

Name of Medication	Dose	Frequency		Name of Medication	Dose	Frequency

Do you Smoke Cigarettes? ______(Y/N)   If Yes, # per day ______ For how long? ________
Do you Drink Alcohol? __________ (Y/N)   If yes, How Much/Quantity per Week? __________
Have you ever participated in Counseling or Psychotherapy? (Y/N)________________________
If yes, Whom____
Type: Individual: _______ Family _______ Couples________ Substance abuse __________

Check if YOU have or had any of the following:

Condition	Check	Condition	Check	Condition	Check
Cancer (Active)		Asthma		Irregular Heartbeat	
Diabetes		Anemia		Phlebitis	
Kidney Disease (Dialysis) ESRD		Chest Pain		Low Back Pain	
Severe Depression		Chronic Diarrhea		Epilepsy	
Celiac		Chronic Constipation		Seizures	
Heart Disease		Fainting		Shortness of Breath	
Liver Disease		Frequent Headaches		Sleep Difficulties	
Kidney Disease (Non-Dialysis)		Frequent Nausea		Stroke	
		Gallbladder Disease		Swelling of Feet	
Cancer (Previously)		Gout		Thyroid Disease	
High Blood Pressure		Heartburn Allergies		Ulcers	
High Cholesterol		Dizziness		Yellowing	
Lap band		Arthritis		Hemorrhoids	
Gastric Bypass		Alcoholism/Drug Abuse		Neuropathy	
Anxiety/Panic Attacks		Mild Depression			

For Women Only:Please check ALL that Currently Apply

Do you have an IUD		**Do you take Birth Control**		**Hormone Replacement Therapy**	
E-sure		**Use any other form of Birth Control**		**Are you Pregnant or Planning to be Pregnant (next 6 months)**	
PCOS		**Full Hysterectomy**		**Partial Hysterectomy**	

Do you still menstruate regularly? _______Yes ________No
If No, When did you Stop Menstruating and Why?________________________________

Primary Care Physician:
Full Name: ____________________________________
Address: ____
Phone Number: ____________________

Additional Care Provider(s)
Full Name: ____________________________________
Address: ____
Phone Number: ________________________

Consent to Contact PCP or Other Health Care Providers:

______________________ ________________
Sign Date