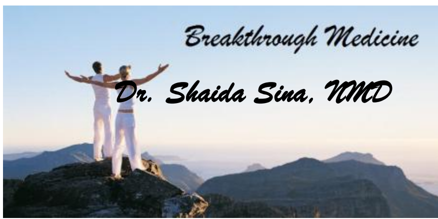


Patient Visit Location:
702 S. Main St. Cottonwood, AZ 86326

Male Return Visit Update

Last name: ____________ **First:** ____________ **Middle:** ____________

Address: ________________________ **Phone#:** ____________

Occupation: **Employer:** **Employer Ph#:**

List reason for visit: (e.g. chest cold, pain, prescription renewal, lab review, drug side effect, detox inquiry, specialist referral needed, annual checkup, etc.) Please place in order of importance.

1.	2.
3.	4.
5.	6.

Please list prescriptions you may need refilled (by name):

List all Labs, Reports, Bloodwork, Thermal, Mammograms, Bone Density, X-Rays, Hair Analysis, Stool Testing, etc.

Changes in your health since your last visit? Yes / No. If "Yes" please explain below: Major life change (divorce, death in family, new job, etc.)

1.	2.
3.	4.
5.	6.
7.	8.

Have you see another medical provider, had a medical procedure, gone to urgent care, the emergency room or been hospitalized since our last visit? __________ If yes list provider's name, medical facility, and reason?

1.	2.
3.	4.

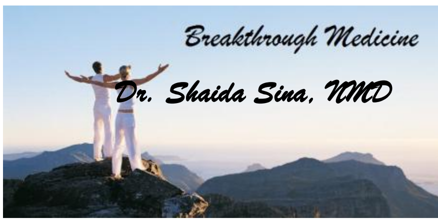
Please list all current medications dosages, and how you are taking your medication. Please note any changes since your last visit such as side effects and having to stop medication or reducing dose.

1.	2.
3.	4.
5.	6.

List what you're really taking in supplements, doses, and how you are taking (such as once daily, twice daily or at bedtime):

1.	2.
3.	4.
5.	6.
7.	8.

Ph: 928.649.0269 FAX: 866.644.6363 Email: office@breakthroughmed.com



Patient Visit Location:
702 S. Main St. Cottonwood, AZ 86326

HEALTH PROFILE

NAME ______________________ DATE____________

Rate each of the following symptoms upon your typical health profile for:

Point Scale	
0	*Never* or *Almost never* have the symptom
1	*Occasionally* have it, effect is *not severe*
2	*Occasionally* have it, effect is *severe*
3	*Frequently* have it, effect is *not severe*
4	*Frequently* have it, effect is *severe*

Head
____ Headaches
____ Faintness
____ Dizziness
____ Insomnia
[ ] TOTAL

Eyes
____ Watery or itchy eyes
____ Swollen, reddened or sticky eyelids
____ Bags or dark circles under eyes
____ Unusual blurred or tunnel vision
[ ] TOTAL

Ears
____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears, hearing loss
[ ] TOTAL

Nose
____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucous formation
[ ] TOTAL

Mouth Throat
____ Chronic coughing
____ Gagging, freq. Need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums, lips
____ Canker sores
[ ] TOTAL

Skin
____ Acne
____ Hives, rashes, dry skin
____ Hair loss
____ Flushing, hot flashes
____ Excessive sweating
[ ] TOTAL

Heart
____ Irregular or skipped heart beat
____ Rapid or pounding heartbeat
____ Chest pain
[ ] TOTAL

Lungs
____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing
[ ] TOTAL

Digestive Tract
____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal / stomach pain
[ ] TOTAL

Joints/ Muscles
____ Pain or aches in joints
____ Arthritis
____ Stiffness /limitation of movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness
[ ] TOTAL

Weight
____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight
[ ] TOTAL

Energy/ Activity
____ Fatigue, sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness
[ ] TOTAL

Mind
____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty in making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities
[ ] TOTAL

Emotions
____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression
[ ] TOTAL

Other
____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge
[ ] TOTAL

HEALTH PROFILE GRAND TOTAL ___________

MALE HORMONE SURVEY

Please score: BLANK = No Symptoms
USE 1-5 (1=Mild 5=Severe)

Symptom	Score
Constipation	
Muscle Pain	
Joint Pain	
Low sex drive	
Erectile firmness	
Erectile stamina	
Decreased ejaculate	
Unable to climax	
Fatigue	
Loss of motivation	
Decreased strength	
Decreased endurance	
Depression	
Anxiety	
Mood Swings	
Foggy thinking	
Adult acne	
Difficulty passing urine	
Pain with passing urine	
Dry skin	
Thinning hair	
Anger / Irritability	
Breast enlargement	
Increase in abdomen girth	
Insomnia	
Weight gain	
Rapid weight loss	
Over sensitive / weepy	
Thinning of skin	

HORMONE SURVEY TOTAL _____

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