BLLV
BODY LOUNGE | LAS VEGAS

modern male
MEN'S WELLNESS CENTER

❑ BOTOX/ JUVEDERM ❑ BEAUTY ❑ WEIGHT LOSS

❑ OTHER ❑ HORMONES ❑ ENERGY/DETOX ❑ MODERN MALE

How did you hear about us?_____

Patient Name _____

Birth Date_____ SS#/DL#_____

Phone#_____ Cell#_____ E-Mail_____

Address _____

City_____ State_____ Zip Code_____

Provider _____

Employer Name _____ Occupation_____

Emergency Contact _____ Relationship_____

Contact Number_____

I understand that I am responsible for the payment of all services rendered. The above information provided is true to the best of my knowledge. I agree that my before and after pictures may be used to inform new patients, as well as for marketing and promotional purposes.

SIGNATURE_____ **DATE**_____

FAMILY HISTORY

- ❑ Obesity
- ❑ Depression
- ❑ Anxiety
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Seizures
- ❑ Kidney/Liver/Disorders
- ❑ Breast Cancer
- ❑ Cervical or Ovarian Cancer
- ❑ Blood Disorders
- ❑ High Cholesterol
- ❑ Thyroid Disease
- ❑ Other Cancer (please describe)

_____

HEALTH HABITS

Do you smoke? YES NO Have you ever smoked? YES NO

If yes, how many years have you smoked?_____ Packs per day?_____

Do you drink Alcoholic beverages? YES NO

If yes, how often? ❑ Frequently ❑ Occasionally ❑ Seldom

Do you exercise? YES NO

How often? ❑ 1-2x per week ❑ 3-4 per week ❑ Everyday

Type of Exercise: ❑ Walking ❑ Jogging ❑ Bicycling ❑ Yoga ❑ Skiing ❑ Aerobics

❑ Other_____

Do you feel as though you exercise without getting the results you should be getting? YES NO

WEIGHT MANAGEMENT QUESTIONS

Age:_____ Current Weight:_____

Do you believe you are overweight? YES NO

If yes, how many pounds?_____

Do you consider yourself obese? YES NO

Were there prior diets you responded to? YES NO

If yes what were they?_____

PERSONAL PATIENT MEDICAL HISTORY

- ❑ Obesity
- ❑ Depression
- ❑ Anxiety
- ❑ High Blood Pressure
- ❑ Stroke
- ❑ Skin Lesions
- ❑ Cold Sores
- ❑ Burn Easy
- ❑ Burn Rarely
- ❑ Heart Disease
- ❑ Diabetes
- ❑ Seizures
- ❑ Kidney/Liver/Disorders
- ❑ Cancer
- ❑ Skin Disease
- ❑ Herpes
- ❑ Burn Sometimes
- ❑ Burn Always
- ❑ Headaches
- ❑ HIV/AIDS
- ❑ Migraines
- ❑ Glaucoma
- ❑ Arthritis
- ❑ Keloid Scar
- ❑ Sun Tan (how often) _____
- ❑ Other _____ _____

MEDICAL HISTORY FOR WOMEN

Are you menopausal? YES NO

Are you Peri-Menopausal? YES NO

Are you on any kind of birth control? YES NO

HEALTH HABITS

❑ Hormone Disorder ❑ Thyroid Disorder ❑ Irregular Menstrual Cycles

Do you have a physician? _____ When was your last physical?_____

Have you had a pap smear in the last year? YES NO

Mammogram in the last year? YES NO

Other Disorders? _____

_____

PLEASE LIST ALL CURRENT MEDICATIONS YOU ARE TAKING
(INCLUDE PRESCRIPTIONS, OVER THE COUNTER DRUGS, VITAMINS ECT.)

_____

_____

Drug Allergies? YES NO
If yes, please list:

_____

_____

Hospitalizations History (other than minor injuries):

_____

_____