MedHealth 360

AESTHETICA
Cosmetic Surgery & Laser Center

COSMETIC SURGERY & LASER CENTER
Phillip J. Chang, M.D.
Board Certified Plastic Surgeon

# Wellness Screening

**Name:** ______________________________ **Date:** ______________

**Date of Birth:** ______________________________ **Weight:** ______________

| | Never | Mild *(some days)* | Moderate *(most days)* | Severe *(everyday)* |
|---|---|---|---|---|
| 1. Decline in general well being | 1 | 2 | 3 | 4 |
| 2. Joint pain/muscle ache | 1 | 2 | 3 | 4 |
| 3. Excessive sweating/hot flashes | 1 | 2 | 3 | 4 |
| 4. Sleep problems | 1 | 2 | 3 | 4 |
| 5. Irritability | 1 | 2 | 3 | 4 |
| 6. Nervousness | 1 | 2 | 3 | 4 |
| 7. Anxiety | 1 | 2 | 3 | 4 |
| 8. Depressed mood | 1 | 2 | 3 | 4 |
| 9. Exhaustion/tired | 1 | 2 | 3 | 4 |
| 10. Declining mental ability/focus/concentration | 1 | 2 | 3 | 4 |
| 11. Decreased muscle strength | 1 | 2 | 3 | 4 |
| 12. Weight gain/increased belly fat/inability to lose | 1 | 2 | 3 | 4 |
| 13. Breast tenderness | 1 | 2 | 3 | 4 |
| 14. Rapid hair loss | 1 | 2 | 3 | 4 |
| 15. Migraines | 1 | 2 | 3 | 4 |
| 16. Decreased sexual libido/desire | 1 | 2 | 3 | 4 |
| 17. Decreased ability to perform or climax | 1 | 2 | 3 | 4 |
| 18. Dry skin | 1 | 2 | 3 | 4 |
| 19. Cold all the time | 1 | 2 | 3 | 4 |
| 20. Constipation | 1 | 2 | 3 | 4 |
| 21. White spots on nails | 1 | 2 | 3 | 4 |
| 22. Bruise easily | 1 | 2 | 3 | 4 |
| 23. Loud noises bother you | 1 | 2 | 3 | 4 |
| 24. Frequent heartburn | 1 | 2 | 3 | 4 |
| 25. Wake up tired | 1 | 2 | 3 | 4 |

**Total**

**0-40: Fairly healthy; 40-60: Some hormonal imbalance is likely; 60 or more: Deficiency is probable**

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## Top 5 Main Concerns:

Please elaborate on the symptoms and frequency that you experience your primary concerns.

______________________________________________________________

______________________________________________________________

______________________________________________________________

What kinds of alternate therapies have you tried?

______________________________________________________________

Allergies: ________________________

Medications: ________________________

Date of last menstrual period: ________________________

Medical History/Chronic Illness: ________________________

| | | | | | |
|---|---|---|---|---|---|
| Are you on birth control? | Yes | No | Testicular cancer? | Yes | No |
| Hysterectomy? | Yes | No | Diabetes? | Yes | No |
| Do you have ovaries? | Yes | No | Colon cancer? | Yes | No |
| Currently on hormones? | Yes | No | Liver disease? | Yes | No |
| History of breast cancer? | Yes | No | Renal disease? | Yes | No |
| Fibrocystic breast disease? | Yes | No | Acne? | Yes | No |
| Uterine ablation? | Yes | No | Prostate cancer? | Yes | No |
| Metabolic disease? | Yes | No | | | |

I hereby consent to Dr Chang or his office staff to draw my blood for testing. I understand that blood draw may lead to bruising, swelling, discomfort, bleeding at the site of blood draw. Results from my lab work will be reviewed over the phone or may be left on voicemail.

Phone number: ________________________

Patient Name : ________________________

Patient Signature: ________________________ Date: ________________________

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