



Steve Samuel M.D.
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Michael A. Samuel M.D.

Body Allure Health Patient Intake Form

Date: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Wk Phone: _____

Mobile Phone: _____

E-Mail address: _____

Emergency Contact: _____

Phone Number: _____ Relationship to: _____

The following is a list of questions that will assist Dr. Michael and Steve Samuel in helping you achieve your health goals. Please answer each question completely. If the question does not apply to you, please indicate with "N/A." Dr. Michael and Steve Samuel and/or staff will analyze this information to design a personalized health program. This questionnaire is held in the strictest confidence..



Please tell us your **Health Goals**, the **Purpose of Your** consultation and your **Desired Results** from the program:

Please list any health concerns:

1

2

3

4

5

Medical History

Please list any medical problems you are currently seeing a medical professional for and the age you were diagnosed.

Past Surgeries: please list all



Please list all of your current Medications prescribed by a health care professional:

Please List all of your current Supplements (nutritional/vitamins/herbal/et.):

Please list all **Drug Allergies**:

Are you concerned with your hormonal health? If yes please list symptoms you are having that you feel are hormone related:



Family History

Please indicate any Family Medical History. Please list age of onset and death if applicable:

Father

Mother

Children

Siblings

Social History

Do you smoke? (If yes how often)?

Do you drink alcohol? (If yes how often)?

Do you use other tobacco? (If yes how often)?

Do you have a good support system for your health program?(If yes, who)?



Lifestyle and Behavioral History

Please list **any/all diets** you have been on in the past. Please indicate how you did on each one.

Please list **any/all exercise programs** you have done in the past, or are currently doing.

What exercise modalities do you have available today?

General Early Detection

The following is a list of Early Detection Procedures. Please indicate if you have had the procedure, when you had the procedure, and the result:

Exercise Stress Test _____

Colon Studies _____

EKG _____

Blood test for Infectious disease _____

Chest X-Ray _____

Blood Sugar Tests _____



BODYALLURE

Dental and Oral Exams _____

Skin Exam _____

Immunizations _____

MALE

PSA _____

Prostate Exam _____

FEMALE

Pap Smear _____

Mammogram _____

Sleep History/Inventory

Usual Bedtime: _____

Average number of hours slept: _____

Do you have difficulty falling asleep _____

How do you feel upon awakening _____

After going to bed, number of trips to the bathroom: _____

Do you use any sleep aids _____

Do you snore _____



Do you grind your teeth_____

Other problems/concerns_____

Stress History/Inventory

On a scale of 1-10, 1 being no stress and 10 being the worst stress, what is your overall stress rating_____

What are your sources of stress_____

Do you feel you have stress related health problems_____

What do you do to relax and relieve stress_____

What is your response to stress and Frustration_____