IV4U HYDRATION LOUNGE
INTAKE HISTORY

* indicates a required field

Please answer these questions truthfully and to the best of your knowledge. This will allow us to design a treatment plan specifically designed for you. Your honest answers are greatly appreciated. If it does not apply, write N/A.

NAME:_____

DOB:_____

ADDRESS:_____

PHONE NUMBER:_____

EMAIL ADDRESS:_____

Personal Health History

* How did you hear about us?

* What are your goals for treatment? Do you have any specific concerns you would like addressed?

* Please list any medical conditions you have been diagnosed with such as high blood pressure.

Surgeries:

Hospitalizations:

Have you ever been on testosterone replacement? Please describe your history of prescribed or illicit steroid use:

List any medications or supplements you are taking:

* Please list any drug allergies you have:

Health Habits

* Exercise:

- ☐ Sedentary
- ☐ Mild exercise

- [ ] Moderate exercise
- [ ] Regular vigorous exercise

* Are you dieting?

* Please describe your alcohol intake:

* Do you use tobacco? How much?

* Do you use any recreational or street drugs? If so, what?

* Are you sexually active?
- [ ] Yes
- [ ] No

*Any discomfort with intercourse?
- [ ] Yes
- [ ] No

*Have you been diagnosed with HIV?
- [ ] Yes
- [ ] No

Family Health History

* Please describe your family health history. Please include conditions such as prostate cancer, heart attacks, stroke, diabetes, high blood pressure etc. Please also include their age or if they are deceased.
- [ ] Father
- [ ] Mother
- [ ] Paternal Grandmother
- [ ] Paternal Grandfather
- [ ] Maternal Grandmother
- [ ] Maternal Grandfather
- [ ] Siblings
- [ ] Children
- [ ] Unknown

Mental Health

* Do you have anxiety problems?

- [ ] Yes
- [ ] No

* Do you feel depressed?

- [ ] Yes
- [ ] No

* Do you have problems with eating or your appetite?

- [ ] Yes
- [ ] No

* Do you feel unmotivated in life?

- [ ] Yes
- [ ] No

* Do you have trouble sleeping?

- [ ] Yes
- [ ] No

Men Only

* Do you have to get up to urinate at night?

- [ ] Yes
- [ ] No

* Do you have discomfort with urination?

- [ ] Yes
- [ ] No

* Has the force of your urination decreased?

- [ ] Yes
- [ ] No

* Have you had any kidney, bladder, or prostate infections within the last 12 months?

- [ ] Yes
- [ ] No

* Do you have any problems emptying your bladder completely?

- [ ] Yes
- [ ] No

* Do you have problems achieving or maintain an erection?

- [ ] Yes
- [ ] No

* Are your erections softer than they used to be?

- [ ] Yes
- [ ] No

* Do you have ejaculation issues?

- [ ] Yes
- [ ] No

* Any testicle pain or swelling?

- [ ] Yes
- [ ] No

* Date of last prostate and rectal exam:_____

Please explain any yes answers from the previous questions or tell us anything else you would like us to know:

Other recent problems:

* Please check if you have any additional issues and briefly explain:

- [ ] Skin
- [ ] Head/Neck
- [ ] Ears/Throat/Nose
- [ ] Lungs
- [ ] Chest/Heart
- [ ] Joint/Muscle/Back
- [ ] Gastrointestinal
- [ ] Bladder
- [ ] Mental health
- [ ] Sexual health
- [ ] Athletic performance
- [ ] Recent changes in weight

- [ ] Recent changes in energy levels
- [ ] Recent changes in ability to sleep
- [ ] Recent changes in libido or erection quality
- [ ] Recent changes in anything else
- [ ] Not applicable

* Please rate each problem from a scale to 1-10, with 1 being never and 10 being often:

- [ ] Low mood/Depression
- [ ] Irritability
- [ ] Anxiety
- [ ] Anger
- [ ] Discouragement
- [ ] Decreased interest in activities or relationships
- [ ] Decreased productivity at work
- [ ] Decreased motivation/drive/initiative
- [ ] Concentration problems
- [ ] Memory problems
- [ ] Foggy thinking
- [ ] Lower libido/sex drive
- [ ] Erection problems
- [ ] Increased fatigue
- [ ] Decrease in muscle mass
- [ ] Decrease in athletic performance
- [ ] Muscle soreness/fatigue
- [ ] Decrease in strength
- [ ] Joint problems
- [ ] Elevated blood pressure
- [ ] Blood sugar problems
- [ ] Sweet/carb cravings
- [ ] Caffeine Cravings
- [ ] Increased fat on hips/abdomen/thighs/chest

- [ ] Weight loss
- [ ] Weight gain
- [ ] Hair loss
- [ ] Anything else you would to mention

Additional Services

* Please indicate services you are interested in:

- [ ] Testosterone Replacement Therapy
- [ ] Erectile Dysfunction Treatment
- [ ] Growth Hormone Optimization
- [ ] Nutritional Supplementation
- [ ] Anti-Aging Services

PLEASE RETURN FORMS TO IV4UHYDRATIONLOUNGE@GMAIL.COM OR FAX TO (813) 891-1660