



CENTER FOR  
PELVIC HEALTH AND WELLNESS

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Reason for visit today** (Check all that apply):

- Low Testosterone/Male Hormone Balance
- Create a Wellness Lifestyle
- Lose Weight- Sculpt- Tone Body -Emsculpt- Emtone- Emsella
- Sexual Health and Couple Wellness
- Other \_\_\_\_\_

**Please list your 3 major health goals in order of priority:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Rate your Symptoms:**

Symptoms	Never	Mild	Mod	Severe
Sweating (night sweats or excessive sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems (difficulty falling asleep, sleeping through the night or waking too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased need for sleep or falls asleep after meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (restless, feeling panicked, nervous, tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (decrease in endurance, muscle strength, fatigue, lack of stamina)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in desire or performance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty urinating, frequent urination)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erectile changes (weaker, loss of morning erections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain fog, Problems with thinking, poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase frequency of headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid hair loss or thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all of the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain, increased belly fat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infrequent or absent ejaculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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**Patterns** Please mark frequency of activity per week:

Lift weights \_\_\_\_\_ Exercise \_\_\_\_\_ Get Outside \_\_\_\_\_

Skip Meals \_\_\_\_\_ Enjoy Work \_\_\_\_\_ Sit at Computer \_\_\_\_\_

Sleep Well \_\_\_\_\_ Self Care \_\_\_\_\_ Nicotine \_\_\_\_\_

Meditate/Prayer \_\_\_\_\_ Intimacy \_\_\_\_\_ Move Bowels \_\_\_\_\_

**Hydration** What is your average daily intake? (oz)

Water \_\_\_\_\_ Caffeine \_\_\_\_\_ Alcohol \_\_\_\_\_ Soda \_\_\_\_\_

Juices \_\_\_\_\_ Milk \_\_\_\_\_ Energy Drinks \_\_\_\_\_

Other \_\_\_\_\_

**Fuel** What % do you eat of the following daily?

Dairy % \_\_\_\_\_ Fats % \_\_\_\_\_ Vegetables % \_\_\_\_\_

Animal protein % \_\_\_\_\_ Grains % \_\_\_\_\_

Fruit % \_\_\_\_\_ Processed foods % \_\_\_\_\_

**Wellness** Mark the wellness practices you use:

Acupuncture  Chiropractic  Physical Therapy

Yoga  Massage  Nutritional Counseling

Eye Care  Exercise/Movement Classes

Psychological Services  Supplements

Dental Care  Regular Check-ups

<b>Past Dietary Changes</b> Check all that apply, what, when?	<b>Past Treatments</b> Check all that apply, what, when?
<input type="checkbox"/> Dietary changes <input type="checkbox"/> Keto /Paleo <input type="checkbox"/> Anti-Inflammatory <input type="checkbox"/> FODMAP <input type="checkbox"/> Low Fat- Low Carb <input type="checkbox"/> High Fiber <input type="checkbox"/> Low Residue <input type="checkbox"/> Vegan or Plant Based <input type="checkbox"/> Mediterranean <input type="checkbox"/> Weight Watchers <input type="checkbox"/> V-Shred <input type="checkbox"/> Beach Body <input type="checkbox"/> Intermittent Fasting, Type _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Diet Medications _____ <input type="checkbox"/> Diet Supplements _____ <input type="checkbox"/> Liposuction – Cool Sculpt <input type="checkbox"/> HIFEM (Emsculpt, Emtone, or Emsella) <input type="checkbox"/> BioTe or Sotopelle Hormone Pellets <input type="checkbox"/> Bio-identical Hormone Therapy _____ <input type="checkbox"/> Lubricants _____ <input type="checkbox"/> Viagra, Cialis, injectables <input type="checkbox"/> OShot or PRP <input type="checkbox"/> Pelvic Physical Therapy <input type="checkbox"/> Couples or Individual Therapy <input type="checkbox"/> Other _____



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<b>MEDICAL HISTORY</b>	Please <b>check</b> all that apply:					☐ I have no medical problems – go to next section.					
	Self	Siblings	Mom	Dad	GPs		Self	Siblings	Mom	Dad	GPs
ADD/ADHD/ASD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroidism/Hashimotos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension/High Bld Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroidism/Graves/Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypercholesterolemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune System- Weak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BPH- Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Disc Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough/COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbar Disc Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep Vein Thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Renal Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Conditions _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastroesophageal Reflux/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma (narrow/wide angle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder/Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____					

<b>SURGICAL HISTORY</b>	Please <b>circle</b> any surgeries that you have had indicate <b>year</b> :		☐ I have never had surgery- go to next section.	
Abdominal Surgery _____	Hernia Surgery			
Appendectomy	Hip Surgery _____	Replacement R/L		
Abdominoplasty/tummy tuck	Knee Surgery _____	Replacement R/L		
Anal/Rectal Surgery _____	Laparoscopy, for _____			
Back Surgery _____	Pacemaker			
CABG _____ x Vessels	Prostate Surgery _____			
Cervical conization/LEEP	Removal of Adhesions			
Cholecystectomy (removal of the gallbladder)	Spinal Stimulator/ InterStim			
Facial Surgery _____	Testicular Surgery _____			
	Other _____			



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<b>MEDICATIONS</b>		Please <b>list all</b> current medications, vitamins, supplements	If you have a list please provide
Name	Dosage	How often	Reason for Medication

<b>ALLERGIES</b>	Please <b>list all</b> allergies, including drugs, iodine, shellfish, latex	<input type="checkbox"/> <b>I have no Drug Allergies</b>

<b>SOCIAL HISTORY</b>	
<b>Occupation:</b>	<input type="checkbox"/> Not currently working outside the home <input type="checkbox"/> Retired <input type="checkbox"/> Working---Vocation _____
<b>Relationship Status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married, happily- Yes or No <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
<b>Tobacco:</b>	<input type="checkbox"/> I have never smoked - go to next section. <input type="checkbox"/> Quit smoking    < 5 years ago    5-10 years ago    > 10 years ago Number of Years using Tobacco _____ Number of Cigarettes per day _____
<b>Alcohol:</b>	<input type="checkbox"/> I never drink alcohol - go to next section. <input type="checkbox"/> Drinks per day _____ <input type="checkbox"/> Drinks per week _____
<b>Do you or have you used any of the following:</b>	
<input type="checkbox"/> CBD products (edibles, CBD oil, smoking, or topicals) <input type="checkbox"/> Stimulants (cocaine, Adderall) <input type="checkbox"/> Injectables (Heroin) <input type="checkbox"/> Medications not prescribed to you (opioids (Percocet or Vicodin), sedatives (Valium or Xanax) <input type="checkbox"/> Cigars <input type="checkbox"/> Anabolic steroids	

<b>MALE HISTORY</b>			
<b>Sexual History</b>	<b>Prostate Cancer Screening</b>	<b>Children</b>	<b>Contraceptive History</b>
<b>Sexual History</b> <input type="checkbox"/> I am not sexually active <input type="checkbox"/> I am sexually active  <input type="checkbox"/> I have sexual wellness concerns <input type="checkbox"/> Low sex drive <input type="checkbox"/> Erectile issues <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Peyronies disease <input type="checkbox"/> Pain with erection  <input type="checkbox"/> Sexual Orientation <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Other	Have you ever had an abnormal PSA? Yes or No Have you had treatment BPH If so: When _____ What treatment _____ Have you had treatment for Prostate Cancer? If so: When _____ What treatment _____ Have you had the HPV vaccine Yes or No  <b>Infection History</b> Have you ever had? <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <input type="checkbox"/> Other _____	<input type="checkbox"/> I have no children  <input type="checkbox"/> I have fathered ___ children	<input type="checkbox"/> I am not using contraception  I have questions about contraception Yes or No  Are you using any birth control now? _____ Past use of: <input type="checkbox"/> Abstinence <input type="checkbox"/> Barrier method (condom) <input type="checkbox"/> Vasectomy <input type="checkbox"/> Depends on partner <input type="checkbox"/> Other



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<b>REVIEW OF SYSTEMS</b> Please <b>circle all</b> symptoms that you currently have <b>now or in past 2 weeks:</b>			
<b>Constitutional</b> Chills Fever Weight Gain/Loss Loss of Appetite Fatigue Sleep Disturbance	<b>Chest</b> Pain Nipple Discharge Mass	<b>Respiratory</b> Cough Shortness of Breath Wheezing/Asthma Use of Inhaler	<b>Urinary Tract</b> Frequent Urination Urgency Loss of Urine Frequent Bladder Infections Burning with Urination Blood in Urine Low flow urine Leakage of urine
<b>Eyes</b> Blurred Vision/Double Vision Glasses/Contacts Eye Pain Watery eyes/Itchy Eyes	<b>Gastrointestinal</b> Reflux Constipations Diarrhea Nausea/Vomiting Change in Stools Blood in Stools Bloating Stool loss	<b>Neurologic</b> Weakness Impaired Balance Headache/Migraines Confusion Numbness/Tingling Memory Loss Brain Fog Learning Disabilities	<b>Genitourinary</b> Bent penis Low sex drive Erectile issues Penile discharge Penile pain Testicular pain
<b>Ears/Nose/Throat</b> Dry Mouth Hearing Loss Ringing in the ears Sinus Trouble Sore Throat Denture Use Allergic Symptoms	<b>Musculoskeletal</b> Joint Pain Back/Neck Pain Muscle Aches Joint Swelling Fall/Trauma Use of Cane/Walker Tight Muscles Leg Swelling	<b>Hematologic</b> Easy Bleeding Easy Bruising Blood Thinners  <b>Endocrine</b> Increased thirst Changes in Blood Sugars	<b>Sexual/ Hormone Balance</b> Lack of Desire Problems with Orgasm Relationship Issues Pain with Intercourse Mood Swings Weight Problems Brain Fog Forgetfulness Mood Changes Sleep Disturbance
<b>Cardiovascular</b> Chest Pain Palpitations/Irregular heart beat Murmur	<b>Skin</b> Rash/Itching Increased Hair Growth Hair Loss Acne/Eczema/Dry skin	<b>Emotional</b> Anxiety Panic Attacks Depression Irritability	

**HEALTH MAINTENANCE:**

Colonoscopy \_\_\_\_\_ Bone Density \_\_\_\_\_ Health Screen Lab Tests \_\_\_\_\_ PSA \_\_\_\_\_ Urology Exam \_\_\_\_\_  
 Date of last: \_\_\_\_\_