Update Form

List Current Medications

DOSEAGE AND FREQUENCY

****Must be written at each visit**

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List New Medical Conditions/Diagnoses_____
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List Allergies
_____
_____
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_____

Name:_____**Date**_____

Do You/Have_____	**YES**	**NO**
Smoke		
Drink Alcohol		
Falls or Fainting		
Seizures		
Hypertension		
Diabetes		
Have Restless Legs		
Sensitive to Noise		
Ringing in Ears		
Tremors		
Dizziness		
ADD		
***Forgetfulness/Brain fog**		
***Decreased sexual function**		
***Insomnia**		
***Fatigue/Weakness/Low Energy**		
***Depressed mood**		
***Feel Anxious**		
***Stubborn belly fat**		
***Hot flashes/sweating**		
_***Irritability**_____	_____	_____
* **These are symptoms of testosterone and estrogen imbalance-discuss with provider**		