



History and Physical for HCG

Name: _____ Date: _____ Age: _____

Do you have any allergies to medicines?

What effects?

1. _____
2. _____
3. _____
4. _____
5. _____

Are you on any current medications? (Including over-the-counter and herbal supplements.)

Name	Dose	Frequency
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

Do you have a history of any of the following conditions?

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Rheumatic pains | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Menstrual disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Breathlessness or exertion | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Angina/Chest Pain |
| <input type="checkbox"/> Thyroid Deficiency | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Insomnia | |

Do you feel the need to eat snacks between meals? _____

If female, when was your last menstrual period? _____

Duration of treatment? 3 wks ___ 6 wks ___

How did you hear about the Mondello Medical Spa? _____