revive rejuvenate
by Dr. Ubaldo Mendiola

Patient Information Form

Patient Name: _____ Weight: _____. Hight: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: D O B :

Occupation:

Who is your primary care physician? _____

How did you hear about our clinic?

☐ Google
☐ IG FB
☐ Patient Referral: _____
☐ Friend: _____
☐ Dr. Referral:
☐

What is the nature of your visit?

_____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

Are you pregnant? ☐ No ☐ Yes

Have you or do you still have:	No	Yes	Description
1. Asthma	☐	☐	
2. Emphysema	☐	☐	
3. High Blood Pressure	☐	☐	
4. Heart Trouble	☐	☐	
5. Hepatitis or Liver Trouble	☐	☐	
6. Kidney Trouble	☐	☐	
7. Diabetes	☐	☐	
8. Epilepsy or Seizures	☐	☐	
9. Stroke	☐	☐	
10. Problem Scarring	☐	☐	
11. Have you been advised to or had psychiatric care?	☐	☐	
12. Others Not Listed:			

Section III : Family History

Have any blood relatives had any of the following?	No	Yes	Description
1. Cancer	☐	☐	
2. Bleeding Tendency	☐	☐	
3. Leukemia	☐	☐	
4. Heart Disease	☐	☐	
5. High Blood Pressure	☐	☐	
6. Repeated Infections	☐	☐	
7. Asthma	☐	☐	
8. Severe Allergies	☐	☐	
9. Kidney Disease	☐	☐	
10. Arthritis	☐	☐	
11. Mental Illness	☐	☐	
12. Obesity	☐	☐	
13. Thyroid problems	☐	☐	
14. Diabetes	☐	☐	

Section V: Symptoms List:

	Symptoms	YES	NO
1	Absence of morning erection		
2	Absence of zest for life		
3	Achy joints		
4	Acne as an adult		
5	Alzheimer's		
6	Arthritis		
7	Autoimmune disorder		
8	Belly fat		
9	Bladder infection/leak		
10	Bone loss		
11	Brain fog		
12	Brittle nails		
13	Carpal tunnel syndrome		
14	Cellulite		
15	Chronic infections		
16	Cold backside		
17	Cold hands/feet		
18	Cold intolerance		
19	Concentration difficulty		
20	Constipation		
21	Dementia		
22	Depression		
23	Diabetes (Type 2)		
24	Dizziness		
25	Dry eyes		
26	Enlarge prostate		
27	Erectile dysfunction		
28	Excessive ear wax		
29	Exhaustion		
30	Facial hair increase		
31	Fatigue		
32	Fatty clavicles		
33	Fibromyalgia		
34	Fluid retention		
35	Food craving		
36	Forgetfulness		
37	Frailty		
38	Frequent illness		
39	Frequent naps		
40	Frequent UTIs		
41	Goiter		
42	Grumpiness		
43	Hair breakage		

	Symptoms	YES	NO
44	Hair loss		
45	Hard/round stools		
46	Heart disease		
47	Heart palpitations		
48	Heavy periods		
49	High blood pressure		
50	High cortisol levels		
51	High cholesterol		
52	High insulin levels		
53	Hoarse/husky voice		
54	Hypoglycemia		
55	IBS		
56	Infertility		
57	Infrequent sexual climax		
58	Insomnia		
59	Irritability		
60	Lack of sex drive		
61	Light-headedness		
62	Loss of curves		
63	Loss of energy		
64	Loss of enjoyment		
65	Loss of stamina		
66	Low body temperature		
67	Lupus		
68	Man bobs		
69	Migraines		
70	Miscarriages		
71	Mood swings		
72	Muscle loss		
73	Muscle pain		
74	Muscle weakness		
75	Nausea		
76	Nervousness		
77	Obesity		
78	Osteoporosis		
79	Panic attacks		
80	Parkinson's		
81	Poor memory		
82	Prediabetes		
83	Puffy/bags under eyes		
84	Ridged nails		
85	Ringing in the ears		
86	Sagging breasts		

	Symptoms	YES	NO
87	Salt craving		
88	Sarcopenia		
89	Scleroderma		
90	Skin wrinkles		
91	Slow metabolism		
92	Strokes		
93	Sweating		
94	Sweet cravings		
95	Swollen jawline		
96	Thinning eyebrows		
97	Thinning skin		
98	Tremors		
99	Turned down lip corners		
100	Virginal dryness		
101	Weight gain		
102	Worse allergies		

Section VI: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

Section VII: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

_____

_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____