

Confidential Medical History Form Health Coaching Session

I REALIZE THIS MEDICAL HISTORY FORM IS SOMEWHAT LONG. HOWEVER, IT IS ABSOLUTELY NECESSARY FOR ME TO EVALUATE YOUR GENERAL HEALTH. MAKE SURE TO TAKE A FEW MINUTES TO CAREFULLY AND COMPLETELY ANSWER EVERY QUESTION. FAILING TO DO SO WILL PREVENT ME FROM HELPING YOU AS WELL AS I COULD. DO THE BEST YOU CAN- I WILL FOLLOW-UP WITH ANY QUESTIONS I MAY HAVE. REMEMBER, THIS INFORMATION IS COMPLETELY CONFIDENTIAL.

Please initial here that you have read the above statement: _____

OPTIMUM REQUIRED LAB WORK (Preferred but not mandatory)

<http://www.discountedlabs.com/hormon...panel-for-men/>

1 ----- Estradiol- ultrasensitive via LC/MS test (not EIA!) [Quest Labs code 30289]
(Labcorp code: 140244) (baseline, week 6 or 8, month 6)

GOAL: 20-50 pg/mL

2 ----- Testosterone, Free, Bio/Total (LC/MS/MS) (baseline, week 6-8, month 6, then yearly)

GOAL: Total testosterone over 500 ng/mL and free T 2 percent or more of total T.

3 ----- DHEAs (baseline, month 6, month 12 (if supplementing))

4 ----- Comprehensive Metabolic Panel w/EGFR (baseline, week 6-8, month 6 and then once a year)

GOAL: Normal CBC including liver enzyme elevations under 20 percent and eGFR over 60

5 ----- CBC w/ diff/PLT (baselines, week 6-8, month 6 and then once or twice per year)

GOAL: Normal CBC

6 ----- Lipid profile (fasting sample) (baselines, month 6, then once per year unless high)

GOAL: Normal lipids

7 ----- T3, free (for those with low thyroid symptoms)

GOAL: Upper quartile free T3

8 ----- T4, free (for those with low thyroid symptoms)

Goal: Normal free T4

9 ----- Ultrasensitive TSH (baseline, month 6, yearly after that depending on value and treatment)

GOAL: TSH under 2.5

10 ----- Prostatic Specific Antigen (PSA) (Baseline before testosterone treatment, 6-8 weeks after and then yearly)

GOAL: PSA under 3

11----- LH and FSH (for men not on testosterone yet)- Used to diagnosed primary or secondary hypogonadism. Do not waste money testing your LH and FSH if you are on testosterone since they will be undetectable.

For those with excessive fatigue: Saliva Cortisol + DHEA (4 specimens during one day) (you can wait for after 6 weeks on TRT). Ferritin is also a test that can be considered.

GOAL: Normal cortisol graph and values along with proper cortisol/DHEA ratios

Will you have a copy of that report and any labs sent to me before our consultation (email: nelsonvergel@gmail.com, or fax 713-529-5303)? _____

First name: _____

Middle name: _____

Last name: _____

Address: _____

City: _____

State: _____

Zip code: _____

Can you describe the primary goal and outcome that you want from a consultation?

CONTACT INFORMATION

Email: _____

Repeat Email Address [to confirm]: _____

Daytime phone: _____

Nighttime phone: _____

HEALTH AND QUALITY OF LIFE INFORMATION:

Age: _____

Height: _____

Weight: _____

Waist size: _____

Neck size: _____

Marital status? _____

Do you have small children? _____

Do you still want to have children? _____

Have you lost weight in the past 6 months? If yes, how many pounds? _____

Have you gained weight in past 6 months? If yes, how many pounds? _____

Has your body tone changed in the past 6 months (harder, softer)? _____

When was your last complete physical examination? _____

What were the results of that exam? _____

(FOR OVER 40) Did you have your prostate examined by digital rectal exam? _____

(FOR OVER 40) Did you have your PSA checked? _____

If so, what was it? _____

Are you taking testosterone now? _____

If answer to above question is NO, have you taken testosterone in the past? How long and when did you last stop? _____

Do you urinate alright (you fully void)? _____

How many times do you get up at night to urinate? _____

Does it hurt when you urinate? _____

Is there any blood in your urine? _____

Have you had prostatitis (prostate/urinary infections) in the past? _____

Describe any acne history: _____

Did you have gynecomastia (increased breast tissue swelling) when young? _____

Do you have cold intolerance? _____

Do you bruise easily? _____

Do you have:

Depression _____

Anxiety _____

Decreased sexual potency (erection quality). If so, is this causing stress in your relationship? _____

Decreased sex drive _____

Do you have morning erections? _____ If yes, how many times per week (estimate)? _____

Do you feel your testicles are smaller than they used to be? _____

Sleep disturbances _____

Generalized muscle aches and pains _____

Joint pain _____

Fatigue _____

Lethargy _____

Diabetes _____

Previous heart attack _____

Previous clotting issues _____

Leg/ankle swelling _____

Sensitive or swollen nipples? _____

Can you feel any lumps around your nipples? _____

Are you losing your hair? _____

Have you ever taken Propecia or Proscar (finasteride) for hair loss or prostate inflammation or Accutane for acne? _____

Have you had a traumatic head injury? _____

Have you taken pain killers (opiates) for several months? _____

DIET AND EXERCISE

Tell us about your diet (The more details, the better)

Do you exercise? If yes, what type and how frequently?

Do you feel that you procrastinate a lot and do not have enough mental focus to finish projects? _____

Are you experiencing a lot of stress lately? For how long and why? _____

MEDICATIONS AND SUPPLEMENTS

Do you take any prescription medications or medications bought on the internet or black market?

If so, please list, and give dosages:

What supplements do you take (vitamins, minerals, nutraceuticals, etc.)? List all (with amounts or dosages) each day.

QUESTIONS FOR STEROID USERS ONLY

How many times have you been on a steroid cycle (if any)? _____

How long ago was your first steroid cycle (if any)? _____

How long was your break before starting this cycle? _____

Were you losing it before you started using steroids (AAS only)? If so, is it falling out more quickly now? _____

Did you have swollen or painful nipples BEFORE you ever used steroids (for men who have used anabolics steroids- AAS)? _____

Have you needed to donate blood or get a therapeutic phlebotomy due to high hematocrit (red blood cell volume)? _____

Describe your past usage, if any, of hCG, Nolvadex, Clomid, Arimidex or finasteride: _____

Have you ever had any problems (side effects) with any of the medications mentioned in the last question If so, please describe:

Did you use a post-cycle therapy (PCT) program after stopping the cycle (s)? If yes, please describe:

Did you get your total and free testosterone tested after PCT? _____

Add any other pertinent information about your health not covered by the above questions:

SLEEP

Have you ever been diagnosed with sleep apnea via a sleep study? If yes, do you use a CPAP machine? _____

Do you take frequent naps? _____

Do you feel refreshed when you wake up in the morning? _____

Average hours of sleep per night: _____

Do you usually go to bed after 10 pm ? _____

How long did it usually take for you to fall asleep during the past 4 weeks?

(Select One)

0-15 minutes.....1

16-30 minutes.....2

31-45 minutes.....3

46-60 minutes.....4

More than 60 minutes.....5

On the average, how many hours did you sleep each night during the past 4 weeks?

Write in number

of hours per night:

How often during the past 4 weeks did you...

	(Select One Number On Each Line)					
	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
feel that your sleep was not quiet (moving restlessly, feeling tense, speaking, etc., while sleeping)?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
get enough sleep to feel rested upon waking in the morning?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
awaken short of breath or with a headache?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
feel drowsy or sleepy during the day?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
have trouble falling asleep?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
awaken during your sleep time and have trouble falling asleep again?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
have trouble staying awake during the day?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
snore during your sleep?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
take naps (5 minutes or longer) during the day?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
get the amount of sleep you needed?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>

The information that I will receive in the consultation is for educational purposes only, and is in no way a substitute for the advice of a qualified health care provider. I understand that appropriate medical therapy and the use of pharmaceutical compounds like testosterone should be tailored for the individual, as no two individuals are alike. I understand that Nelson Vergel does not recommend self-medicating with any compound, as I should consult with a qualified medical doctor who can determine my individual situation. I understand that any use of the information presented to me in the consultation is done strictly at my own risk and no responsibility is implied or intended on the part of Nelson Vergel.

Signed: _____

Date: _____