



**Lutz office**  
4691 Van Dyke Road  
Lutz, FL 33558

**Largo Office**  
1033 West Bay Drive, Suite B  
Largo, FL 33770

## History and Physical

Thank you for choosing Evolution. Our goal is to provide our patients with professional, therapeutic care tailored to meet each patient's unique medical needs. Our courteous staff is ready and willing to assist you with any questions or concerns that you may have regarding your treatment. The information requested below is necessary for the preparation of your medical records. If the patient is a minor, this form may be completed and signed by the parent or guardian who will be responsible for payment.

### How did you find out about Evolution:

Online    Billboard    Newspaper: \_\_\_\_\_  Friend/Co-Worker: \_\_\_\_\_

Physician: \_\_\_\_\_  Other: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Driver's License Number: \_\_\_\_\_ State: \_\_\_\_

Primary Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Secondary Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

If minor, responsible party's name: \_\_\_\_\_ Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Reason for Visit (please check all that apply):

- Weight loss (see Weight History section)  
 Hormones (please fill out appropriate Hormone Questionnaire)  
 Anti – Aging  
 Other: \_\_\_\_\_

**P: 813-333-5593, Fax: 813-235-4135**

\* Erin Bolton, Functional Medicine Specialist

\* Christopher Van Benschoten, MD

**Email: [admin@evo4health.com](mailto:admin@evo4health.com) • Website: [www.Evolution4Health.com](http://www.Evolution4Health.com)**



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## History and Physical

Heart Disease	Yes	No	HIV/AIDS	Yes	No	Mumps	Yes	No
High Blood Pressure	Yes	No	Mono	Yes	No	Measles	Yes	No
Low Blood Pressure	Yes	No	Hepatitis	Yes	No	Chicken Pox	Yes	No
Lung Disease	Yes	No	Hemorrhoids	Yes	No	Smallpox	Yes	No
Kidney Disease	Yes	No	Ulcers	Yes	No	Whooping Cough	Yes	No
Liver Disease	Yes	No	Hernia	Yes	No	Scarlet Fever	Yes	No
Thyroid Disease	Yes	No	Asthma	Yes	No	Polio	Yes	No
Diabetes	Yes	No	Sinusitis	Yes	No	Rheumatic Fever	Yes	No
Heart Murmur	Yes	No	Colitis	Yes	No	Bladder Infection	Yes	No
Prolapsed Mitral Valve	Yes	No	Diphtheria	Yes	No	Hives or Eczema	Yes	No
Tuberculosis	Yes	No	Venereal Disease	Yes	No	Hearing Loss	Yes	No
Bronchitis	Yes	No	Anemia	Yes	No	Pacemaker	Yes	No
Glaucoma	Yes	No	Blood Transfusions	Yes	No	Metal Implants	Yes	No
Arthritis	Yes	No	Artificial Prosthesis	Yes	No	Migraine Headaches	Yes	No
Stroke	Yes	No	Pregnant	Yes	No	Back Trouble	Yes	No
Epilepsy	Yes	No	Last Menstrual Cycle date			Swollen Ankles	Yes	No
Cancer	Yes	No	Last Pregnancy date			Psychiatric Disorders	Yes	No

Please list any previous hospitalizations/surgeries/serious illnesses you have or have had in the past:

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Please list any and all allergies:

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Please list any medications that you are currently taking, including over the counter, with dosage:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Alcohol Use:     Never     Rarely     Moderate     Daily

Drug Use:     Never     Rarely     Moderate     Daily

Tobacco Use:     Never     Previously Quit: \_\_\_/\_\_\_/\_\_\_  
 Rarely     Moderate     Daily     Current Packs Per Day: \_\_\_\_\_

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## Permission to Treat

I, the undersigned, hereby voluntarily consent to the medical care/diagnostic treatment by Evolution, deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as I result of treatment or examination in the office. I have freely provided all of the information disclosed in this History & Physical packet for the continued medical care/diagnostic treatment by Evolution, deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that all sales are final for professional fees and medications.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

## Office Policies

Evolution requests that any cancellations be made 24-hrs prior to scheduled appointment to better serve all patients. I understand that my credit card will be charged a \$40 NO CALL/NO SHOW fee by the end of the business day on the day of my appointment should I fail to call or reschedule 24 hours prior to the time of my appointment.

Please call office for refill request at least one week prior to running out of medications. It may be required to have filling pharmacy fax a refill request.

Diagnostic & laboratory results are not discussed by phone or provided via email. They are freely given upon request and during appointment to review results. Should you require them prior to appointment, please contact lab wherein collection occurred.

**X** \_\_\_\_\_  
Patient Signature

**X** \_\_\_\_\_  
Date

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## Female Questionnaire

	NONE	MILD	MODERATE	SEVERE		NONE	MILD	MODERATE	SEVERE
<u>Hot Flashes</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Allergies</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Foggy Thinking</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Acne</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Aggressive Behavior</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Dizzy Feeling</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Mood Swings/Irritability</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Nausea</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Anxiety/Nervousness</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Decreased Stamina</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Depression/Sadness</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Cold Body Temp</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Night Sweats</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Swelling Eyes/Face</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Sleep Disturbance</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Brittle Nails</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Forgetful</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Brittle Hair/Loss</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Headaches/Migraines</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Oily or Dry Skin/Hair</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Morning Fatigue</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Hoarseness</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Afternoon Fatigue</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Weight Gain</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Evening Fatigue</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Sugar/Salty Cravings</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Trouble Losing Weight</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Constipation</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Increased Facial Hair</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Regular Bowel Movements</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Retain Water</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Stool Float</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Tender Breasts</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Stool Sink</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Decreased Libido</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Loose Stools</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Pain During Intercourse</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Abdominal Bloating</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Vaginal Dryness</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Urinary Urges</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Clotting During Menses</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Incontinence</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Extra Vaginal Discharge</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Belching</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Thick Blood</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Snore</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Bruise Easily</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Decreased Muscle Mass</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Shortness of Breath</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Rapid Aging</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Aches/Pains</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Acid Reflux/Heartburn</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>
<u>Flatulence</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>Difficulty Swallowing</u>	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>

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## Female Questionnaire Continued

	<u>Yes</u>	<u>No</u>	<u>Off-On</u>
<u>Feel Wired &amp; Tired but Can't Sleep</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Sleep Apnea</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>History of PCOS</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Endometriosis</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Uterine/Vaginal Procedures</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Yeasty/Fishy odor with vaginal discharge</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Full Hysterectomies</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Partial Hysterectomies</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hashimotos</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Anemia</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Goiter</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Fibromyalgia</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Numbness in Hands or Feet</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Fibrocystic Breasts</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cysts/Tumors</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Uterine Fibroids</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Irregular Menstrual Cycle</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Infertility</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ringing in Ears</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>High Cholesterol</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Average Hours Sleep at Night (1-10) \_\_\_\_\_

Pregnancies (1-10) \_\_\_\_\_

Miscarriages (1-10) \_\_\_\_\_

Have you had Labs/Blood Work done recently? \_\_\_\_\_

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If So When? \_\_\_\_\_

Have you had your Hormones/Adrenals \_\_\_\_\_

Checked? \_\_\_\_\_

If so when? \_\_\_\_\_

Do you Exercise? \_\_\_\_\_

How Often? \_\_\_\_\_

If Not, Would you be interested in a Daily Workout regimen? \_\_\_\_\_

What is your Daily Water Intake? \_\_\_\_\_

How would you Describe your Nutritional Habits? \_\_\_\_\_

Is there anything that you feel you would like to add that has Not been previously mentioned?

\_\_\_\_\_

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# HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

**By signing this form, I understand that:**

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- EVOLUTION reserves the right to change the privacy policy as allowed by law.
- EVOLUTION has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- EVOLUTION may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	<b>YES</b>	<b>NO</b>
May we leave a message on your answering machine at home or on your cell phone?	<b>YES</b>	<b>NO</b>
May we discuss your medical condition with any member of your family?	<b>YES</b>	<b>NO</b>

If **YES**, please name the members allowed:

\_\_\_\_\_

\_\_\_\_\_

**This consent was signed by:** \_\_\_\_\_  
**(PRINT NAME PLEASE)**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## Credit Card Authorization Form

Please complete all fields with valid credit card information.

You may cancel this authorization at any time by contacting us.

This authorization will remain in effect until cancelled and/or replaced by another valid credit card.

Credit Card Information Card Type:  MasterCard  VISA  Discover  AMEX

Other \_\_\_\_\_

Cardholder Name (as shown on card): \_\_\_\_\_

Card Number: \_\_\_\_\_

Card CCV Code: \_\_\_\_\_

Expiration Date (MM/YY): \_\_\_\_\_

Cardholder ZIP Code (from credit card billing address): \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_ EVOLUTION \_\_\_\_\_ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I understand that my credit card will be charged a \$40 NO CALL/NO SHOW fee by the end of the business day on the day of my appointment should I fail to call or reschedule 24 hours prior to the time of my appointment. I understand that the above credit card must be valid at all times and it is my responsibility as the card holder to report a change in card information and/or change in card currently kept on file should the use of another card be required. I am aware that it is my responsibility as card holder to request a certain card be used for payment if I have multiple cards on file upon checkout. I understand that I am able to request a card be deleted from my account provided I have multiple cards on file, all current cards on file are valid and up to date, and/or I have a valid replacement card to put on my account.

**X** \_\_\_\_\_  
Patient Signature

**X** \_\_\_\_\_  
Date

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