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: _____

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Weight Loss

Height: ____'____"

Present Weight: _____

Lowest Adult Weight: _____

Highest Adult Weight: _____

Goal Weight: _____

When did you first become overweight?

_____

Do you have any members in your family who are considered overweight?

_____

Have you tried other weight loss programs or methods before? If so, please list them.

_____

Do you think you have a weight problem? If so, can you please explain why you think that is?

_____

Do you Exercise? _____

How Often? _____

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

What are your expectations from Evolution Weight Loss?

_____

P: 813-333-5593, Fax: 813-235-4135
* Erin Bolton, Functional Medicine Specialist
*Christopher Van Benschoten, MD
Email: ***admin@evo4health.com*** • ***Website:*** 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:

_____
_____
_____

Please list any and all allergies:

_____

_____

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

_____ _____
_____ _____
_____ _____
_____ _____

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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Male Questionnaire

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

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Male Questionnaire Continued

	Yes	No	Off-On
Feel Wired & Tired but Can't Sleep	☐	☐	☐
Sleep Apnea	☐	☐	☐
Hashimotos	☐	☐	☐
Anemia	☐	☐	☐
Goiter	☐	☐	☐
Fibromyalgia	☐	☐	☐
Numbness in Hands or Feet	☐	☐	☐
Cysts/Tumors	☐	☐	☐
Infertility	☐	☐	☐
Do you have children	☐	☐	☐
Want more children	☐	☐	☐
Ringing in ears	☐	☐	☐
High Cholesterol	☐	☐	☐
Morning Erections	☐	☐	☐
History of Steriod Use	☐	☐	☐
History of Illegal Drugs	☐	☐	☐
Ever Have Estrogen Checked	☐	☐	☐
Sexual Desire	☐	☐	☐
Work out/Exercise	☐	☐	☐
Does it take long to recover	☐	☐	☐
Auto Immune Disease	☐	☐	☐

Average Hours Sleep at Night (1-10) _____

Have you had Labs/Blood Work done recently?_____

If So When? _____

Have you had your Hormones/Adrenals_____

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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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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_____ **X**_____

Patient Signature Date

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: _____

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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?	**YES**	**NO**
May we leave a message on your answering machine at home or on your cell phone?	**YES**	**NO**
May we discuss your medical condition with any member of your family?	**YES**	**NO**

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_____ **X**_____

Patient Signature Date

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