Pacific Wellness Clinic
of Ventura
A Medical Practice Dedicated to the Advancement of Wellness
and Anti-aging Medicine

2807 Loma Vista Road, Ste. 101
Ventura, California 93003
Phone: (805) 652-0524

PATIENT INFORMATION AND REGISTRATION

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Sex: Male or Female Date of Birth: _____ Marital Status: M S M D W

Email Address: _____

Driver's License# _____ SSN#: _____

Employer: _____ Work Phone: _____

Employer Address: _____

Name of Spouse: _____ Date of Birth: _____

In An Emergency,
Relative Not Living with You: _____ Phone: _____

Address _____ Relationship: _____

Family Doctor: _____ Phone: _____

Address: _____

Financial Information: Person responsible for fees

Name: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

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PATIENT MEDICAL INFORMATION

Name: _____ **Age:** _____

Date of Birth _____ **Gender:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Preferred Pharmacy: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

List your top 3 Health Goals

1. _____
2. _____
3. _____

Allergies to Drugs: (CIRCLE) ☐ None

Latex Penicillin Sulfa I VP Dye List any other allergies: _____

_____

Current Medications (list dose and frequency) ☐ None

_____
_____
_____
_____

Current Herbs and Supplements (list dose and frequency) ☐ None

_____
_____
_____
_____

Operations/ Surgeries: (Circle all that apply) ☐ No Surgery History

Appendectomy Back/Neck Surgery Bladder Repair Gallbladder removal Hernia TURP
Heart Bypass Heart Stents Kidney Removal Kidney Stone Hysterectomy Vasectomy
TUR Bladder Tumor

Other:_____

_____

_____

_____

Medical Conditions / date of onset: (Circle all that apply) ☐ None

Heart Problems: ☐ **None** High Blood Pressure Heart Attack Heart Murmur Arrhythmia
Congestive Heart Failure Mitral valve insufficiency Atrial fibrillation Atherosclerosis

Respiratory Problems: ☐ **None** Asthma Emphysema Pneumonia Shortness of breath
COPD Pulmonary hypertension Lung Cancer

Other: _____

Hormone Disorders: (Circle all that apply) ☐ **None**

Gonadal Thyroid Adrenal Pancreatic Pituitary Menopausal

Genitourinary Disorders: (Circle all that apply) ☐ **None**

Impotence Kidney stones Infections Incontinence Urinary frequency Hematuria

Infectious Disorders: (Circle all that apply) ☐ **None**

Tuberculosis HIV(AIDS) Hepatitis

Neurologic Disorders: (Circle all that apply) ☐ **None**

Seizures Head Injury Stroke Headaches Parkinsons Disease Multiple Sclerosis

Others:_____

_____

_____

Family Medical History: ☐ None ☐ Unknown

Mother: _____

Father: _____

Siblings: _____

Other Family Member: _____

Social History:

- Do you currently smoke? ☐ Yes ☐ No

  ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Electronic Smoking Device ☐ Chewing Tobacco

  ☐ Other: _____

  How many packs per day? ½ 1 2 3

  Total number of years you have smoked: _____

  If you used to smoke, when did you quit? _____

- Do you drink alcohol? ☐ Yes ☐ No

  Wine, Beer or Hard Liquor? _____

  Drinks per day: _____ Drinks per week: _____

- Do you drink caffeinated beverages? ☐ Yes ☐ No How much _____
- Have you had Blood Transfusions? ☐ Yes ☐ No If yes, when _____
- Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
- How many children do you have? _____ ☐ None
- What is your occupation? _____
- When was your last...

Physical: _____ Where? _____

Chest X-ray: _____ CT Scan: _____

EKG: _____ Colonoscopy: _____

Thermography / Mammogram: _____ Pap Smear: _____

Other: _____

- **PLEASE CIRCLE IF YOU** CURRENTLY **HAVE ANY OF THE FOLLOWING SYMPTOMS:**
  - **General/Constitutional:** Fever, Weight Loss, Chills
  - **Eyes, Ears, Nose, Throat:** Blurry Vision, Cataracts, Hearing Loss
  - **Cardiovascular/Respiratory:** Chest Pains, Swollen Ankles, Shortness of Breath
  - **Genitourinary:** Incontinence, Painful Urination, Blood in Urine
  - **Musculoskeletal/Neurologic:** Chronic Back Pain, Chronic Neck Pain, Numbness
  - **Integumentary/Skin:** Rash, Persistent Itching Skin, Cancer History
  - **Hematologic/Lymphatic:** Swollen Glands, Abnormal Bleeding, Transfusion History

For Women Only

- Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure

  Number of pregnancies _____

  Age at first pregnancy _____
- Age of first menses _____
- Last menstrual period _____
- Duration of periods and quality of period: _____

  _____
- Are you on Hormone Replacement? ☐ Yes ☐ No (If 'Yes," list type and dose)

  _____

  _____

  _____
- Are you on Birth Control? ☐ Yes ☐ No (If "Yes," list type and dose)

  _____

For Men Only:

The International Index of Erectile Function (IIEF-5) Questionnaire

In the last 6 months...

1. ***How do you rate your confidence*** *that you could get and keep an erection:*

_____ Very low **1** Low **2** Moderate **3** High **4** Very High **5**

2. ***When you had erections*** *with sexual stimulation,* ***how often*** *were your erections hard enough for penetration?*

_____ Rarely/never **1** A few **2** About half the time **3** Over 50% of times **4** Nearly Always **5**

3. ***During sexual intercourse, how often*** *were you able to maintain your erection after you had penetrated your partner?*

_____ Rarely/never **1** A few **2** About half the time **3** Over 50% of times **4** Nearly Always **5**

4. ***During sexual intercourse, how difficult*** *was it to maintain your erection to completion of intercourse?*

_____ Extremely difficult **1** Very difficult **2** Difficult **3** Slightly difficult **4** Not difficult **5**

5. ***When you attempted sexual intercourse, how often*** *was it satisfactory for you?*

_____ Rarely/never **1** A few **2** About half the time **3** Over 50% of times **4** Nearly Always **5**

Score: _____