Welcome! Our team is so glad you've chosen Optimyze as your anti-aging and performance specialists!

What's inside: In this packet you will find a detailed medical history questionnaire. Take your time filling it out as it gives us vital information on you as an individual. Please also be sure to have them completed and in our possession prior to your initial appointment. This enables us to streamline, not only your care, but that of all our patients.

What to expect: After your consultation, you will schedule an appointment with Joanna for a lab draw. These typically take 5 full business days for a comprehensive panel to be completed. These tests include several hormone profiles, a complete blood count, a thyroid work up and multiple vitamin levels. For this initial panel, we request you be fasting. To make this process easier for you, we are here Monday through Friday at 7:30am, and earlier upon request.

At your initial office visit with our Nurse Practitioner Robin, you should expect to spend 45 to 60 minutes with her one on one. During this visit you will have the opportunity to go over your medical history and lab results in depth with her. They will also be the opportune time to discuss what your specific concerns or goals are.

Due to the meticulous care, detail and time that we are able to afford our patients, Optimyze does not bill insurance for services provided. All lab work and/or prescription medications may be billed to your private insurance, however, there is no guarantee that they will cover any or all of what is filed. Therefore, we have affordable options for patients that either have no insurance or chose to skip the hassle altogether. Simply ask us here at Optimyze or visit our website optimyzeme.com for promotional offers, events and savings, including referral discounts!

Name:____ DOB:___ /___ /_____ Height:______ Weight:_______

Address:____ City:___________________State:______

Zip:_______

Phone: (_____) ______________ Email: ____

Emergency Contact:______________________________ Relationship:____________ Phone: (____)__________

Local Pharmacy: _______________________________ Location:_________________ Phone: (____)_________

Allergies:____

Primary care doctor:____ Phone: (____)_________

How'd you hear about optimyze?____

Social History				
Cigarettes	☐ ever	☐ former	Daily: ____ cigs/packs	For ____ years
Cigars	☐ never	☐ former	Daily / Weekly: _____	For ____ years
Chewing tobacco	☐ never	☐ former	Specify:	For ____ years
Alcohol	☐ never	☐ former	☐Beer(can/bottle) ☐Wine(glass/bottle) ☐Liquor(shot/drink)	
How many:			☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Socially	
Coffee (cup/pot)	☐ never	☐ __daily	☐ Occasional	☐Regular ☐ Decaf ☐Sweet ☐ Unsweet
Tea	☐ never	☐ __daily	☐ Occasional	☐Regular ☐ Decaf ☐Sweet ☐ Unsweet
Soda (can/bottle)	☐ never	☐ __daily	☐ Occasional	☐Regular ☐Decaf ☐Sweet ☐ Unsweet
Energy Drinks	☐ never	☐ __daily	☐ Occasional	☐Regular ☐Decaf ☐Sweet ☐ Unsweet
Water (bottle/gal)	☐ never	☐ __daily	☐ Occasional	

Occupational Stress: 0(none) 1 2 3 4 5 6 7 8 9 10

Family History				
	Parent	Sibling	Self	Type:
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lung Disease	☐	☐	☐	
Liver Disease	☐	☐	☐	
High Cholesterol	☐	☐	☐	
Anemia	☐	☐	☐	
Thyroid Problems	☐	☐	☐	
Alcohol Abuse	☐	☐	☐	
Drug Abuse	☐	☐	☐	
Weight Problems	☐	☐	☐	
Arthritis	☐	☐	☐	

Other	☐	☐	☐	

Medical History/Major Events/Surgeries		
Disease/Event/Surgery	Date	Outcome/Comments

Current Prescribed Medications				
Medication	Strength	Dose	Frequency	For (diabetes, pain, etc.)

Supplements/Probiotics/Multivitamins

Exercise		
Type (cardio, strength, etc.)	Frequency (daily, per week)	Length/Quantity (60 minutes, 15 reps, etc.)

Current Signs and Symptoms				
	Mild	Moderate	Severe	Comments
Anxiety / depression	☐	☐	☐	
Irritability	☐	☐	☐	
Anger / Aggression	☐	☐	☐	
Low Mood	☐	☐	☐	
Decreased motivation	☐	☐	☐	
Decreased Productivity	☐	☐	☐	
Trouble Concentrating	☐	☐	☐	
Memory / Foggy thinking	☐	☐	☐	
Increased Fatigue	☐	☐	☐	
Decreased stamina	☐	☐	☐	
Decreased athletic performance	☐	☐	☐	
Decrease in lean muscle mass	☐	☐	☐	
Body / joint pain	☐	☐	☐	
Unexplained weight loss or gain	☐	☐	☐	
Increased fat on hips/chest/thighs	☐	☐	☐	
Sweets cravings	☐	☐	☐	
caffeine / stimulant cravings	☐	☐	☐	
Digestive problems	☐	☐	☐	
Hair loss	☐	☐	☐	
Dry / thinning skin	☐	☐	☐	

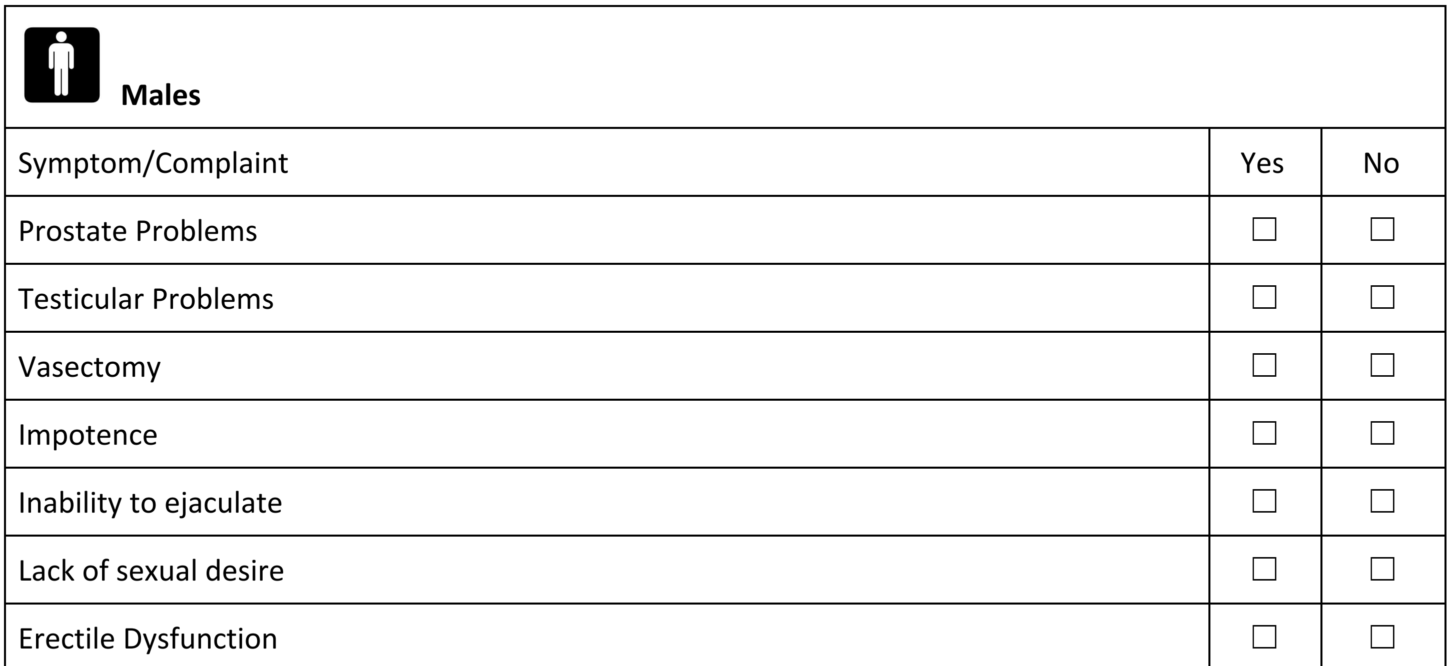
Decreased Libido	☐	☐	☐	

Females

Symptom/Complaint	Yes	No
Menstrual Problems	☐	☐
Premenstrual Tension	☐	☐
Endometriosis	☐	☐
Infertility	☐	☐
Vaginal dryness / itching / discharge	☐	☐
Inability to reach orgasim	☐	☐
Lack of Sexual desire	☐	☐
Breast Tenderness	☐	☐

Date of last period:_____/_____/_____ Birth Control Method: ☐Oral ☐ IUD ☐ None ☐ Other

Number of pregnancies:___ Number of children: ___ Issues during pregnancy: ☐ No ☐ Yes:



Males

Symptom/Complaint	Yes	No
Prostate Problems	☐	☐
Testicular Problems	☐	☐
Vasectomy	☐	☐
Impotence	☐	☐
Inability to ejaculate	☐	☐
Lack of sexual desire	☐	☐
Erectile Dysfunction	☐	☐