DR. MARYANN PREWITT
HealthWellness MD
skinFIT • bodyFIT

Name _____

REASON FOR VISIT: _____
MEDICAL HISTORY (ex: diabetes, hypertension, cholesterol, obesity…)

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____
Any of the following? (Circle) herpes HPV chlamydia gonorrhea HIV genital warts
INCONTINENCE: frequency urgency urine leakage stool/gas leakage

PAST SURGICAL HISTORY (ex: general, plastic surgery, broken bones…)

_____ _____ _____

_____ _____ _____
FAMILY HISTORY (M=mother, F= father, S=sibling, MGM, MGF=mother's parents PGM, PGF=father's parents

_____ _____ _____

_____ _____ _____
SOCIAL HISTORY
Smoker: ___yes ___ no; Alcohol: ___yes/social ___ no; Drug usage: ___yes ___ no; Regular exercise: ___yes ___ no

Safety: Household smoke detector ___yes ___no, Firearms in Home ___yes ___no, Wear Seatbelts ___yes ___no

Sexual Activity: ___ yes ___no; Nutritional Supplements: _____ _____ _____
Marital Status (Circle): Single Married Divorced Widowed

Recent Hospitalizations (within the last year) _____

Immunizations: up to date or unsure

MEDICATION/DOSAGE _____ _____

_____ _____ _____

DRUG ALLERGIES: _____

I REQUEST THE FOLLOWING TESTS

BLOODWORK STD BLOODWORK BONE DENSITY
STD TESTING MAMMOGRAM PREGNANCY TEST

PHARMACY NAME_____ZIPCODE_____

PHARMACY NUMBER _____(WE ESCRIPT RX)

Please describe your skin & other cosmetic concerns by checking all that apply:

___ Acne
___ Fat/Cellulite
___ Double Chin
___ Droopy Eye Lids
___ Facial Redness
___ Fine Lines/Wrinkles
___ Hemorrhoids
___ Lip Lines
___ Saggy Skin
___ Scars
___ Skin Discoloration
___ Skin Tags
___ Stretch Marks
___ Sun Damage
___ Toe Fungus
___ Under Eye Bags
___ Under Eye Dark Circles
___ Unwanted Hair

# WELLNESS CHECKLIST FOR MEN

**Signature:** _____ **Date:** _____

**E-Mail Address:** _____

| **Symptom** ***(please check mark)*** | **Never** | **Mild** | **Moderate** | **Severe** |
|---|---|---|---|---|
| **Decline in general well being** (General state of health) | | | | |
| **Joint pain/muscle ache** (lower back/joint/limb pain) **Excessive sweating** (sudden episodes/hot flash) **Sleep problems** (Difficulty falling/staying asleep/wake up tired) | | | | |
| **Increased need for sleep** (Feel tired often) | | | | |
| **Irritability** (aggressive/easily upset/moody) | | | | |
| **Nervousness** (Inner tension/restlessness) | | | | |
| **Anxiety** (feeling panicky) | | | | |
| **Depressed mood** (Feeling down/sad/lack of drive/nothing of any use) | | | | |
| **Exhaustion/lacking vitality** (Decreased performance & activity/lack of interest/motivation) | | | | |
| **Declining Mental Ability/Focus/Concentration Feeling you have passed your peak** | | | | |
| **Feeling burned out/hit rock bottom** | | | | |
| **Decreased muscle strength** | | | | |
| **Weight Gain/Belly Fat/Inability to Lose Weight** | | | | |
| **Breast Development** | | | | |
| **Shrinking Testicles Rapid** | | | | |
| **Hair Loss** | | | | |
| **Decrease in beard growth New** | | | | |
| **Migraine Headaches Decreased desire/libido Decreased m0orning erections** | | | | |
| **Decreased ability to perform sexually** | | | | |
| **Infrequent or Absent Ejaculations** | | | | |
| **No Results from E.D. Medications** | | | | |

**Other symptoms that concern you:**