MARYCAIREMD

Welcome! Please complete this new client paperwork and return to us **at least 48 hours** prior to your appointment. This will allow our medical team to review your case in advance of your arrival. If you are unable to complete the paperwork prior to your appointment, we will offer your appointment time to another patient on our wait list. You may email this completed document to **support@MaryCaireMD.com** or use our secure fax at **972-943-5973.** Thank you for your help and understanding. Here's to your vitality!

GENERAL INFORMATION		
Full Name:		SSN:
Preferred Name and Title:		
Date of Birth:	Age:	Gender: M F
Drug & Food Allergies:		
Mailing Address:		
City:	State:	Zip:
Email:		Preferred Phone:
Race/Ethnicity: American India Asian African American White Hispanic Other		
Emergency Contact Name:		Relationship:
Phone Number:		Does emergency contact live with you? Y N
Primary Care Physician Name:		Phone:
How did you hear about us?		

INSURANCE INFORMATION		
Primary Insurance Company Name:		
ID Number:	Group Number:	
Address:		
City:	State:	Zip:
Customer Service Phone Number:		
Insured Party Name:		DOB:
Insured Party SSN:		Relation to Patient:

Client Name: _____

MARYCAIREMD

Pharmacy Information			
Pharmacy Name:			
Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
Compounding Pharmacy Name:			
Phone Number:	Fax Number:		

PERSONAL HEALTH + WELLNESS HISTORY

What do you hope to achieve with Mary Caire MD?

How can we best help you achieve your goals?

What are your top three health concerns?

1. _____
2. _____
3. _____

When was the last time you felt well?

Did something trigger a change in your health?

Does anything make you feel worse?

Does anything make you feel better?

FAMILY MEDICAL HISTORY

Relation to You	Age	Alive?	Medical Condition(s)	Cause of Death
Father				
Mother				

Client Name: _____

MARYCAIREMD

Personal Childhood History

☐ How were you delivered? Vaginally C-Section ☐ Did you breastfeed? Y N

☐ Did you experience any childhood illnesses? _____

☐ Other Explanation: _____

Review of Systems: Please appropriate boxes and provide date of onset.

Gastrointestinal

☐ Constipation _____
☐ Diarrhea _____
☐ Irritable Bowel Syndrome _____
☐ Inflammatory Bowel Disease _____
☐ Celiac Disease _____
☐ Bloating, Gas, or Belching _____
☐ Other _____

☐ Ulcerative Colitis _____
☐ GERD/Reflux _____
☐ Crohn's _____
☐ Stomach Pain _____
☐ Stomach Distention _____
☐ Rectal Itching _____
☐ Indigestion _____

Cardiovascular

☐ High Blood Pressure _____
☐ Low Blood Pressure _____
☐ Irregular Heart Rate/Beat _____
☐ Bleeding or Clotting Issues _____
☐ Other _____

☐ Heart Attack _____
☐ High Cholesterol _____
☐ Chest Pain _____
☐ Stroke _____
☐ Dizziness/Fainting _____

Metabolic + Endocrine + Immune

☐ Type 1 Diabetes _____
☐ Type 2 Diabetes _____
☐ Low Blood Sugar _____
☐ Metabolic Syndrome _____
☐ Hypothyroidism _____
☐ Hyperthyroidism _____
☐ Hashimoto's Thyroiditis _____
☐ Chronic Fatigue Syndrome _____
☐ Endocrine Issues _____
☐ Multiple Chemical Sensitivities _____

☐ HIV/AIDS _____
☐ Hepatitis _____
☐ Herpes Virus _____
☐ Lyme's Disease _____
☐ Weight Gain _____
☐ Weight Loss _____
☐ Fibromyalgia _____
☐ Adrenal Fatigue _____
☐ Thinning Eyebrows _____
☐ Other _____

Cancer

Type : _____ Date: _____

Client Name: _____

MARYCAIREMD

Hormones + Sexual Health + Urinary Systems

FEMALE

- ☐ Heavy Menstrual Cycles _____
- ☐ Irregular Menstrual Cycles _____
- ☐ Painful Menstrual Cycles _____
- ☐ Fibrocystic Breasts _____
- ☐ Swollen/Painful Breasts _____
- ☐ Fibroids _____
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Ovarian cysts _____
- ☐ Vaginal Dryness _____
- ☐ Hot Flashes _____
- ☐ Night Sweats _____
- ☐ PMS _____
- ☐ Endometriosis _____
- ☐ Acne/oily skin _____

MALE

- ☐ Prostate Enlargement _____
- ☐ Prostate Infection _____
- ☐ Erectile Dysfunction _____
- ☐ Difficulty Obtaining Erection _____
- ☐ Difficulty Maintaining Erection _____
- ☐ Loss of Morning Erection _____
- ☐ Loss of Ability to Orgasm _____
- ☐ Decreased Libido_____
- ☐ Difficulty Sleeping_____
- ☐ Decreased energy_____

- ☐ Endometriosis _____
- ☐ Hirsutism _____
- ☐ Urinary Tract Infections _____
- ☐ Yeast Infections _____
- ☐ Interstitial Cystitis _____
- ☐ Infertility_____
- ☐ Loss of Libido_____
- ☐ Gout _____
- ☐ Low Energy _____
- ☐ Nocturia (urination at night) _____
- ☐ Loss of Bladder Control _____
- ☐ Endometrial Ablation _____
- ☐ Hysterectomy (Full or Partial)_____
- ☐ Other _____

Respiratory Disease

- ☐ Seasonal/Chronic Allergies _____
- ☐ Chronic Sinusitis _____
- ☐ Food Allergies _____
- ☐ Asthma _____
- ☐ Sleep Apnea _____
- ☐ Other _____

MARYCAIREMD

Skin + Hair + Nails

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Dry Skin _____
- ☐ Nail Fungal Infections_____
- ☐ Acne _____
- ☐ Hair Loss _____
- ☐ Rashes _____
- ☐ Aging Skin _____

Neurologic/Mood

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ Decreased Concentration _____
- ☐ Loss of Motivation _____
- ☐ Short-Term Memory Loss _____
- ☐ Forgetfulness _____
- ☐ Difficulty Finding Words _____
- ☐ Seizures _____
- ☐ ADD/ADHD_____
- ☐ Other _____

Musculoskeletal + Pain

- ☐ Osteoarthritis _____
- ☐ Rheumatoid _____
- ☐ Chronic Pain _____
- ☐ Joint Pain _____
- ☐ Swollen Joints _____
- ☐ Tingling or Numbness _____
- ☐ Radiating/Shooting Pain _____
- ☐ Accident or Injury _____
- ☐ Back/ Neck Problems _____
- ☐ Muscle Pain _____
- ☐ Pain in Arms & Legs_____
- ☐ Weakness _____
- ☐ Loss of Muscle Tone _____
- ☐ Other _____

Preventive Tests + Date of Last Test

- ☐ Complete Physical Exam _____
- ☐ DEXA/Bone Density _____
- ☐ Dental Exam _____
- ☐ EKG _____
- ☐ Cardiac Stress Test _____
- ☐ Eye Exam _____
- ☐ MRI/CT _____
- ☐ Hearing Exam_____
- ☐ Other _____

List any abnormal findings: _____

- ☐ Colonoscopy _____
- ☐ Endoscopy _____
- ☐ Prostate Exam _____
- ☐ Mammogram _____
  - ☐ Normal ☐ Abnormal
- ☐ Pap Smear _____
  - ☐ Normal ☐ Abnormal
- ☐ Pelvic Exam _____

Surgeries

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

MARYCAIREMD

Reason: _____	Date: _____
Hospitalizations(Date and Reason)	

SOCIAL HISTORY		
What is your passion?		
Job Title:	Nature of Business:	
Marital Status:	Partner's Name:	
Who lives at home with you?		
Do you have an excessive amount of stress in your life?		
What is your main source of stress?		
Do you currently smoke?	If yes, how many packs per day?	Years?
Have you ever smoked?	If yes, how many years did you smoke?	
Have you had exposure to second-hand smoke?		
How many hours do you sleep per night on average?		
Do you have trouble sleeping? Y N	Do you have trouble falling asleep or staying asleep? Y N	
Do you wake feeling rested? Y N	Do you snore? Y N	

NUTRITION HISTORY		
Height:	Current Weight:	Desired Weight:
Do you have weight fluctuations of more than 10lbs? Y N		
Do you avoid any particular foods? Y N	If yes, types?	
Do you feel like you digest food well? Y N	Do you feel bloated after meals? Y N	
What are your barriers to eating well?		
Do you drink caffeine? Y N	How many cups/glasses do you drink per day?	
Do you drink sodas or diet sodas? Y N	Do you frequently crave sugar? Y N	

Client Name: _____

MARYCAIREMD

Do you use sweeteners? Y N	How often do you eat sugary foods per week?	
Do you drink alcohol? Y N	How many drinks per week?	
Do you use recreations drugs? Y N	Types?	

EXERCISE HISTORY	
Do you exercise? Y N	Do you exercise at home or in a gym?
What is your current exercise program (activity type, number of sessions/week, duration)?	
List any problems or barriers that limit your activity:	

DENTAL HISTORY	
Do you have mercury fillings? Y N	How many?
Have you ever had a root canal? Y N	How many?
Have you had dental implants? Y N	Do you have tooth or jaw pain? Y N
Do you have bleeding glums? Y N	Do you have gingivitis? Y N
Have you had any dental procedures or oral surgeries? If so, please provide details.	

FEMALE HISTORY		
At what age did you have your first menstrual cycle?		Do you still have a menstrual cycle? Y N
What was the first day of your last cycle?		How many days does your cycle last?
Are your cycles regular? Y N	Painful? Y N	Heavy? Y N
Do you use contraception? Y N		Type(s)?
Are you pregnant or breastfeeding? Y N		Do you plan on becoming pregnant? Y N
Have you ever been pregnant? Pregnancies: _____ C-Sections: _____ Vaginal Deliveries: _____ Miscarriages: _____ Living Children: _____		
Have you had a hysterectomy? Partial (uterus only) Full (uterus & ovaries) No		

Client Name: _____

MARYCAIREMD

MALE HISTORY			
Have you had your PSA level checked? Y N	When was it checked?	Was it normal?	
If have Urologist, please provide full name and phone number.			

CURRENT PRESCRPTION MEDICATIONS (please attach additional sheets if necessary)

Name	Dose	Frequency	Start Date (Mo/Yr)	Reason

CURRENT SUPPLEMENTS (please attach additional sheets if necessary)

Name	Dose	Frequency	Start Date (Mo/Yr)	Reason

Signature: _____ Date: _____

Client Name: _____

MARYCAIREMD

TEMPERATURE – Please take and record your temperatures for 3 days			
	Date	**Time of Day**	**Temperature/Location**
Day 1			
Day 2			
Day 3			

PLEASE COMPLETE THE 3-DAY FOOD JOURNAL

3-DAY FOOD JOURNAL	
Please list everything that you consume for the next three days (including beverages).	
DAY 1	
Breakfast	
Lunch	
Dinner	
Snacks	
How did you feel today?	**Did you experience any physical effects?**
Did you exercise today?	**Did you have a bowel movement today?**

Continued on next page.

Client Name: _____

MARYCAIREMD

DAY 2	
Breakfast	
Lunch	
Dinner	
Snacks	
How did you feel today?	**Did you experience any physical effects?**
Did you exercise today?	**Did you have a bowel movement today?**

DAY 3	
Breakfast	
Lunch	
Dinner	
Snacks	
How did you feel today?	**Did you experience any physical effects?**
Did you exercise today?	**Did you have a bowel movement today?**

Client Name: _____