

# 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: \_\_\_\_\_

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## 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				

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<b>Personal Childhood History</b>	
<input type="checkbox"/> How were you delivered?      Vaginally      C-Section <input type="checkbox"/> Did you breastfeed?      Y      N	
<input type="checkbox"/> Did you experience any childhood illnesses? _____	
<input type="checkbox"/> Other Explanation: _____	
<b>Review of Systems: Please appropriate boxes and provide date of onset.</b>	
<b>Gastrointestinal</b>	
<input type="checkbox"/> Constipation _____ <input type="checkbox"/> Diarrhea _____ <input type="checkbox"/> Irritable Bowel Syndrome _____ <input type="checkbox"/> Inflammatory Bowel Disease _____ <input type="checkbox"/> Celiac Disease _____ <input type="checkbox"/> Bloating, Gas, or Belching _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Ulcerative Colitis _____ <input type="checkbox"/> GERD/Reflux _____ <input type="checkbox"/> Crohn's _____ <input type="checkbox"/> Stomach Pain _____ <input type="checkbox"/> Stomach Distention _____ <input type="checkbox"/> Rectal Itching _____ <input type="checkbox"/> Indigestion _____
<b>Cardiovascular</b>	
<input type="checkbox"/> High Blood Pressure _____ <input type="checkbox"/> Low Blood Pressure _____ <input type="checkbox"/> Irregular Heart Rate/Beat _____ <input type="checkbox"/> Bleeding or Clotting Issues _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Heart Attack _____ <input type="checkbox"/> High Cholesterol _____ <input type="checkbox"/> Chest Pain _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> Dizziness/Fainting _____
<b>Metabolic + Endocrine + Immune</b>	
<input type="checkbox"/> Type 1 Diabetes _____ <input type="checkbox"/> Type 2 Diabetes _____ <input type="checkbox"/> Low Blood Sugar _____ <input type="checkbox"/> Metabolic Syndrome _____ <input type="checkbox"/> Hypothyroidism _____ <input type="checkbox"/> Hyperthyroidism _____ <input type="checkbox"/> Hashimoto's Thyroiditis _____ <input type="checkbox"/> Chronic Fatigue Syndrome _____ <input type="checkbox"/> Endocrine Issues _____ <input type="checkbox"/> Multiple Chemical Sensitivities _____	<input type="checkbox"/> HIV/AIDS _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Herpes Virus _____ <input type="checkbox"/> Lyme's Disease _____ <input type="checkbox"/> Weight Gain _____ <input type="checkbox"/> Weight Loss _____ <input type="checkbox"/> Fibromyalgia _____ <input type="checkbox"/> Adrenal Fatigue _____ <input type="checkbox"/> Thinning Eyebrows _____ <input type="checkbox"/> Other _____
<b>Cancer</b>	
Type : _____ Date: _____	

Client Name: \_\_\_\_\_

## 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 \_\_\_\_\_

- 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 \_\_\_\_\_

### 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 \_\_\_\_\_

## Respiratory Disease

- Seasonal/Chronic Allergies \_\_\_\_\_
- Chronic Sinusitis \_\_\_\_\_
- Food Allergies \_\_\_\_\_

- Asthma \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_
- Other \_\_\_\_\_

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## Skin + Hair + Nails

- |   |   |
|---|---|
| <input type="checkbox"/> Eczema _____                 | <input type="checkbox"/> Acne _____       |
| <input type="checkbox"/> Psoriasis _____              | <input type="checkbox"/> Hair Loss _____  |
| <input type="checkbox"/> Dry Skin _____               | <input type="checkbox"/> Rashes _____     |
| <input type="checkbox"/> Nail Fungal Infections _____ | <input type="checkbox"/> Aging Skin _____ |

## Neurologic/Mood

- |  |   |
|--|---|
| <input type="checkbox"/> Depression _____              | <input type="checkbox"/> Short-Term Memory Loss _____   |
| <input type="checkbox"/> Anxiety _____                 | <input type="checkbox"/> Forgetfulness _____            |
| <input type="checkbox"/> Headaches _____               | <input type="checkbox"/> Difficulty Finding Words _____ |
| <input type="checkbox"/> Migraines _____               | <input type="checkbox"/> Seizures _____                 |
| <input type="checkbox"/> Decreased Concentration _____ | <input type="checkbox"/> ADD/ADHD _____                 |
| <input type="checkbox"/> Loss of Motivation _____      | <input type="checkbox"/> Other _____                    |

## Musculoskeletal + Pain

- |  |  |
|--|--|
| <input type="checkbox"/> Osteoarthritis _____          | <input type="checkbox"/> Accident or Injury _____  |
| <input type="checkbox"/> Rheumatoid _____              | <input type="checkbox"/> Back/ Neck Problems _____ |
| <input type="checkbox"/> Chronic Pain _____            | <input type="checkbox"/> Muscle Pain _____         |
| <input type="checkbox"/> Joint Pain _____              | <input type="checkbox"/> Pain in Arms & Legs _____ |
| <input type="checkbox"/> Swollen Joints _____          | <input type="checkbox"/> Weakness _____            |
| <input type="checkbox"/> Tingling or Numbness _____    | <input type="checkbox"/> Loss of Muscle Tone _____ |
| <input type="checkbox"/> Radiating/Shooting Pain _____ | <input type="checkbox"/> Other _____               |

## Preventive Tests + Date of Last Test

- |   |   |
|---|---|
| <input type="checkbox"/> Complete Physical Exam _____ | <input type="checkbox"/> Colonoscopy _____                        |
| <input type="checkbox"/> DEXA/Bone Density _____      | <input type="checkbox"/> Endoscopy _____                          |
| <input type="checkbox"/> Dental Exam _____            | <input type="checkbox"/> Prostate Exam _____                      |
| <input type="checkbox"/> EKG _____                    | <input type="checkbox"/> Mammogram _____                          |
| <input type="checkbox"/> Cardiac Stress Test _____    | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Eye Exam _____               | <input type="checkbox"/> Pap Smear _____                          |
| <input type="checkbox"/> MRI/CT _____                 | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> Hearing Exam _____           | <input type="checkbox"/> Pelvic Exam _____                        |
| <input type="checkbox"/> Other _____                  |   |

List any abnormal findings: \_\_\_\_\_

## Surgeries

Reason: _____	Date: _____
Reason: _____	Date: _____
Reason: _____	Date: _____

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Reason: _____	Date: _____
<b>Hospitalizations(Date and Reason)</b>	

<b>SOCIAL HISTORY</b>	
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

<b>NUTRITION HISTORY</b>	
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

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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?

<b>EXERCISE HISTORY</b>			
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:			

<b>DENTAL HISTORY</b>					
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.					

<b>FEMALE HISTORY</b>								
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			

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<b>MALE HISTORY</b>			
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.			

<b>CURRENT PRESCRIPTION MEDICATIONS (please attach additional sheets if necessary)</b>				
Name	Dose	Frequency	Start Date (Mo/Yr)	Reason

<b>CURRENT SUPPLEMENTS (please attach additional sheets if necessary)</b>				
Name	Dose	Frequency	Start Date (Mo/Yr)	Reason

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

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

PLEASE COMPLETE THE 3-DAY FOOD JOURNAL

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

Continued on next page.

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

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

Client Name: \_\_\_\_\_