REALRESULTS

General Information

First Name: _____ Last Name:_____
Preferred Name:_____
Date of Birth:_____ Age: _____ Gender: ❑Male ❑Female

Contact Information

Home Address: _____
City:_____ State:_____ Zip:_____
Job Title / Employer: _____
Nature of Business:_____
Home Phone:_____ May we leave a message? ❑Yes ❑No
Cell Phone:_____ May we leave a message? ❑Yes ❑No
Work Phone:_____ May we leave a message? ❑Yes ❑No
Email: _____
Preferred Method of Contact:_____
Emergency Contact Name:_____
Relationship:_____ Phone:_____

Medical Contact Information

Physician/Practice:_____ Phone: _____
Preferred Pharmacy:_____ Phone:_____
Preferred Compounding Pharmacy:_____Phone:_____

Credit Card Information

Please note, no charges will be made to your card without your knowledge. Card on file will be utilized for charging of phone consultation fees, late fees, and any monthly subscription fees, unless other arrangements are made prior to payment due date. Please refer to our Practice Policies for further information.

Primary Card

Name as it Appears on Card:_____
Card Number: _____ ❑Visa ❑MC ❑Discover ❑Amex
Expiration Date:_____ CVV:_____

Insurance Information

Please note, we do not accept insurance, but many of the labs we use do. Please indicate your insurance carrier below so that we may determine the best lab for you.

❑BCBS ❑UHC ❑Cigna ❑Medicare ❑Coventry ❑Other:_____
❑Aetna ❑Humana ❑BCBS NC/Federal ❑Kaiser ❑Tufts ❑Principal ❑No Insurance

Referral Information

How did you hear about us?_____
_____

REALRESULTS

Medical History

Please check the appropriate box to indicate if the medical condition is past (❑) or current (❍).

❑	❍	IBS or IBD	❑	❍	Kidney Disease:
❑	❍	Crohn's or Ulcerative Colitis	❑	❍	Gout
❑	❍	GERD, Reflux, or Peptic Ulcer	❑	❍	Interstitial Cystitis
❑	❍	Celiac Disease or Gluten Sensitive	❑	❍	Frequent UTI or Yeast Infections
❑	❍	Diabetes Type I or II	❑	❍	Sexual Dysfunction
❑	❍	Thyroid Disorder (High or Low)	❑	❍	HSV, Type:
❑	❍	PCOS	❑	❍	HIV/AIDS
❑	❍	Eating Disorder, Type:	❑	❍	Autoimmune Disorder:
❑	❍	Weight Gain or Loss	❑	❍	Asthma
❑	❍	Metabolic Syndrome	❑	❍	Chronic Bronchitis or Emphysema
❑	❍	Infertility	❑	❍	Tuberculosis
❑	❍	Endocrine Disorder:	❑	❍	Sleep Apnea
❑	❍	Heart Disease	❑	❍	Eczema or Psoriasis
❑	❍	Heart Attack	❑	❍	Anxiety or Depression
❑	❍	Stroke	❑	❍	Mood Disorder:
❑	❍	High Blood Pressure	❑	❍	ADD/ADHD
❑	❍	High Cholesterol	❑	❍	Migraine Headaches
❑	❍	Heart Valve Disorder	❑	❍	Seizure Disorder
❑	❍	Arrhythmia/Irregular Heartbeat	❑	❍	Multiple Sclerosis
❑	❍	Cancer:	❑	❍	Cognitive Disorder:
❑	❍	Arthritis, Type:	❑	❍	Other:
❑	❍	Fibromyalgia	❑	❍	Other:
❑	❍	Chronic Pain	❑	❍	Other:

Medical History (continued)

Surgeries: ❑ I have never had surgery

Please list all surgeries and dates (month and/or year are acceptable)

_____

_____

_____

_____

Hospitalizations: ❑ I have never been hospitalized

Please list any overnight hospitalizations, reason for hospitalization, and dates (month/year)

_____

_____

_____

Medications and Supplements: ❑ I am not currently taking any medications

Please list any prescription or over the counter medications or supplements with dosages. We are unable to prescribe or recommend any medications or supplements without this information.

_____

_____

_____

_____

_____

_____

Allergies: ❑ I have no known drug allergies (NKDA)

Please list any allergies to medications or supplements along with the reaction experienced.

_____

_____

Food Allergies: ❑ I have no known food allergies including no allergy to sulfa foods.

Please list any food allergies or sensitivities along with the reaction experienced.

_____

_____

Screening and Preventative Tests:

Please check if you have had any of the following tests in the past 2 years and provide date of testing (month and/or year).

❑ Full Physical Exam_____ ❑ EKG_____ ❑ Cardiac Stress Test_____

❑ Echocardiogram_____ ❑ Colonoscopy_____ ❑ Mammogram_____

❑ Bone Density/DEXA scan_____ ❑ MRI/CT_____area:_____

Comments:_____

Family History:

Mother: ❑Well ❑Deceased ❑Medical Conditions:_____

Father: ❑Well ❑Deceased ❑Medical Conditions:_____

Siblings: ❑Well ❑Deceased ❑Medical Conditions:_____

Medical History (continued)

Social History:

Do you currently use tobacco? ❑Yes ❑No If yes, Form:_____
Amount per day:_____ How many years?_____ Attempts to quit:_____
Previous tobacco use? ❑Yes ❑No If yes, Form:_____
How many years?_____ Date Quit:_____
How many alcoholic drinks do you intake per week? 1 drink = 5oz wine, 12oz beer, 1.5 oz spirits
❑ None ❑ 1-3 ❑ 4-7 ❑ 8-10 ❑ >10
Previous alcohol intake? ❑Yes (❑mild ❑moderate ❑high) ❑No
Caffeine Intake? ❑Yes ❑No If yes, Form:_____ Amount per day:_____
Recreational Substances? ❑Yes ❑No If yes, Form:_____ Amount per day:_____
How many hours of sleep do you average per night? ❑ <6 ❑ 6-8 ❑ 8-10 ❑ >10
Do you: ❑ feel rested on waking ❑ snore ❑ have trouble falling asleep ❑ have restless sleep
Relationship status: ❑Single ❑Married ❑LGBT Relationship ❑Divorced ❑Widow(er)
Do you have children? ❑Yes ❑No If yes, ages:_____

Complaints and Concerns

What do you hope to achieve in your visit with us?_____
_____
_____
If you could magically erase or correct three problems, what would they be?
1._____
2._____
3._____
When did you last feel well?_____
Was there a trigger for the change in your health?_____
_____

Please check any of the symptoms you are currently having or have had in the past 6 months.

❑ Fatigue	❑ Heat intolerance	❑ Dizziness	❑ Wheezing	❑ Shortness of breath
❑ Anxiety	❑ Cold intolerance	❑ Blurry vision	❑ Chest Pain	❑ Difficulty swallowing
❑ Depression	❑ Weight gain/loss	❑ Forgetfulness	❑ Palpitations	❑ Nausea/Vomiting
❑ Irritability	❑ Heartburn	❑ Blood in urine	❑ Cough	❑ Loss of bladder
❑ Diarrhea	❑ Constipation	❑ Blood in stool	❑ Snoring	❑ Sexual dysfunction
❑ Headaches	❑ Easy bruising	❑ Hearing loss	❑ Joint Pain	❑ Decreased libido
❑ Rash	❑ Insomnia	❑ Vision loss	❑ Pain:	

Nutrition and Exercise Review

Nutritional Assessment:

Height (feet, inches) _____	Weight_____
Usual Weight Range +/- 5lbs_____	Desired Weight +/-5lbs_____
Highest Adult Weight_____	Lowest Adult Weight_____
Weight Fluctuations >10lbs ❑ Yes ❑ No	Body Fat %_____

How often do you weigh yourself? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never
Have you ever had a nutritional consultation? ❑ Yes ❑ No
Do you follow a special diet or have any nutritional restrictions? ❑ Yes ❑ No If yes, describe:

_____

Do you read food labels? ❑ Yes ❑ No
Do you grocery shop? ❑ Yes ❑ No If not, who does?_____
Do you cook? ❑ Yes ❑ No If not, who does?_____
How many meals per week are prepared at home? ❑0-3 ❑3-5 ❑5-7 ❑7-10 ❑10-14 ❑ >14
How many meals per week are dine out/take out? ❑0-3 ❑3-5 ❑5-7 ❑7-10 ❑10-14 ❑ >14
Please check any of the following statements that apply to your eating habits:

❑ Fast eater
❑ Eating too much
❑ Love to eat
❑ Late night eating
❑ Dislike healthy food
❑ Time constraints
❑ Eat >50% meals away from home
❑ Travel frequently
❑ Unavailability of healthy foods
❑ Do not plan meals or menus
❑ Rely on convenience items
❑ Poor snack choices
❑ Family members have specific diets
❑ Family members don't like healthy foods
❑ Eat because I have to
❑ Have a negative relationship to food
❑ Struggle with eating issues
❑ Emotional eater (bored, stressed, lonely)
❑ Eat too much under stress
❑ Eat too little under stress
❑ Don't care to cook
❑ Eating in the middle of the night
❑ Confusing nutrition advice
❑ Always hungry / insatiable appetite

Exercise Assessment:

Rate your level of physical activity: ❑ Sedentary ❑Low ❑ Medium ❑ High
Rate your activity level during a typical day (without exercise): ❑ Low ❑ Medium ❑ High

Women's Health Review

Are you currently in menopause? ❑ Yes ❑ No If yes, age at menopause:_____
Do you currently use hormone replacement therapy? ❑ Yes ❑ No
If yes, please explain:_____
Last Menstrual Period: _____ Frequency of Menses: _____ Length:_____
Are your periods: ❑ Irregular ❑ Painful ❑ Heavy ❑ Accompanied by clotting
Do you experience PMS? ❑ Yes ❑ No If yes, list symptoms:_____

_____

Are you currently pregnant, possibly pregnant, or attempting pregnancy? ❑ Yes ❑ No
If yes, please explain:_____

Please check any of the concerns you currently have or have had in the past 6 months:

❑ Hot flashes ❑ Mood swings ❑ Loss of control of urine
❑ Anxiety/Depression ❑ Vaginal Dryness ❑ Weight gain
❑ Decreased Libido ❑ Painful Intercourse ❑ Change in menses

Please list any other concerns you may have here:_____

_____

Men's Health Review

Have you had a PSA done? ❑ Yes ❑ No If yes, list date _____ and level:_____

Please check any of the concerns you currently have or have had in the past 6 months:

❑ Prostate enlargement ❑ Prostate infection
❑ Difficulty obtaining erection ❑ Difficulty maintaining erection
❑ Decreased Libido ❑ Premature ejaculation
❑ Loss of control of urine ❑ Change in urine stream ❑ Difficulty urinating
❑ Frequent nighttime urination, how many times per night?_____

Please list any other concerns you may have here:_____

_____

Readiness Questionnaire

Please rate the following on a scale of 1-5, where 1 = not willing and 5=very willing
In order to improve your health, how willing are you to:

Significantly modify your diet	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Take several nutritional supplements daily	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Keep a daily food log	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Modify your lifestyle (work demands, sleep habits)	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Practice a relaxation technique	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Engage in a regular exercise routine	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1
Have periodic lab tests to assess your progress	❑ 5	❑ 4	❑ 3	❑ 2	❑ 1

Comments:_____

_____

_____

Please rate the following on a scale of 1-5, where 1=very unsupportive and 5=very supportive
How supportive do you feel the members of your household will be to implementing changes?

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

Comments:_____

_____

Acknowledgement of Receipt

By signing below I confirm that I have fully read over and filled out the above health history questionnaire truthfully and accurately. I will now certify that I am under the care of another physician for all other medical conditions. I will consult this physician for any other medical services. I have completely and accurately disclosed any medical conditions and treatments, including prescription and non-prescription medications and supplements. I am aware that a copy of the Practice Policies and Privacy Practices may be reviewed online and provided as a hard copy by request only. I have read and understand the practice policies. I acknowledge by signing that I have also reviewed the NOTICE OF POLICY PROCEDURES, PRIVACY PRACTICES AND NOTICE OF INDIVIDUAL RIGHTS as posted online at www.realresultsforlife.com and do not require a paper copy at this time.By signing this form, I agree to comply with these policies, and provide consent for treatment by Dr. Mildred Santorufo and any designated assistants.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

HSCA/FSCA- I acknowledge that I can use my HSA/FSA account to pay for my services at Real Results and understand that I am liable for payment if my HSA/FSA does not approve my program fees. Initial _____

All Medicare Patients Must Review and Sign Below Prior to Treatment

Notice of Possible Medicare Denial. Medicare will only pay for services deemed reasonable and necessary per section 1862(a)(1) of Medicare Law. Medicare will deny payment for any services considered not acceptable or necessary by Medicare standards. Dr. Mildred Santorufo is not a Medicare provider and therefore payment is due at the time of services rendered. Any claims to medicare must be submitted by the patient and are not guaranteed payment. I have been informed that the services rendered at Real Results will likely be denied by Medicare for reasons stated above.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date