Confidential When Completed	**Dr. Carlos Santo** 14200 N Northsight Blvd Scottsdale, AZ 85260 480.213.8883 602-916-1650 (fax)	Confidential When Completed

Personal Information (please print) **Date**_____

Name _____ Age _____ Date of Birth_____ E-mail _____

Street Address_____ City _____ State _____ Zip _____

Height_____ Weight _____ Gender: M◯ F◯

Home Phone_____ Business Phone _____

Emergency Contact_____ Relationship _____ Phone _____

Whom may we thank for referring you? _____

Health History

In your own words please describe your chief complaint_____

_____

How long have you had the chief complaint? _____

Please list your additional complaints _____

_____

Which diagnoses and or treatments have you received for these conditions? _____

_____

_____

History of abnormal bloodwork (cholesterol, glucose, hormones, iron, etc)? _____

_____

Past Medical History

Condition	Self	Father	Mother	Sibling	Grandparent
Heart Disease	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Mood Disorder (specify)	☐	☐	☐	☐	☐
(specify) _____					
Addiction	☐	☐	☐	☐	☐
(specify) _____					

Past Medical History (Cont'd)

Condition	Self	Father	Mother	Sibling	Grandparent
Cancer	☐	☐	☐	☐	☐
(specify) _____					
Other	☐	☐	☐	☐	☐
(specify) _____					

Past Surgical/Hospitalization History

Date (yyyy)	Procedure	Condition

Allergies

1. Medications _____
2. Foods _____
3. Environmental _____
4. Other _____

Current Medications

	Name	Strength	Amount
1.			
2.			
3.			
4.			
5.			

Current Nutritional Supplements/Herbs

	Name	Strength	Amount
1.			
2.			
3.			
4.			
5.			

Women's Health History

What was your age at the start of menstruation? _____

First date of your last period? _____ How long did it last? _____

How many days between periods? _____ Is your cycle regular? Y ○ N ○

When was your last Pap exam? _____ History of abnormal Pap? Y ○ N ○

When was your last mammogram? _____ History of abnormal mammogram? Y ○ N ○

Pregnancies ____ Living Children ____ Miscarriages ____ Abortions ____

Current and previous methods of contraception
(place a 'c' for current or 'p' for previous in the boxes below)

☐ Not applicable ☐ Hysterectomy (date) ☐ Partner has vasectomy

☐ Condoms ☐ Tubal ligation Other _____

☐ IUD ☐ Diaphragm

☐ Pill (name): _____ years taken: _____

Social History

How often do you exercise? _____

What type of exercise do you participate in? _____

What are your hobbies? _____

Do you smoke cigarettes? _____ If so, how many per day? _____

How would you describe your eating habits? _____

_____

Dietary Profile

How many times per day (D), week (W) or month (M) do you eat, drink or use the following?

Item	D	W	M
Alcohol			
Candy			
Soda pop			
Refined sugar			
Artificial sweetener			
Margarine			
Milk products			
Wheat products			
Red meat			
Pork			
Poultry			
Seafood			
Fruits			
Vegetables			
Nuts/seeds			
Beans			
Tap water (glasses)			
Purified water			
Juices			
Sweetened juices			
Cigarettes			
Chewing tobacco			
Coffee			
Tea			

Please provide any further information you would like to share below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DIRECTIONS: Please read each description and select the number which best describes the frequency of your symptoms within the past year. If you do not understand a symptom put a ? In the box.

KEY

0 = N/A	1 = Mild	2 = Moderate	3 = Severe
(Not Applicable/Never)	(Occurs once a month or less)	(Occurs several times a month)	(Aware of it almost constantly)

PART III

CATEGORY I

Section A:	
1. Bad breath, halitosis	
2. Loss of taste for high protein foods (meat, etc.)	
3. Burning (“acid”) or nervous stomach, eating relieves	
4. Gas shortly after eating	
5. Indigestion ½ to 1 hour after eating may last 3 - 4 hrs	
6. Difficulty digesting fruits or vegetables; undigested foods found in stools	
7. Acid or spicy foods upset stomach	
Section B:	
8. Lower bowel gas and or bloating several hours after eating	
9. Feet burn	
10. "Whites" of eyes (sciera) yellow	
11. Dry Skin, itchy feet and/or skin peels on feet	
12. Brown spots or bronzing of skin	
13. Bitter metallic taste in mouth	
14. Blurred vision	
15. Headache over eyes	
16. Feel nauseous, queasy or gag easily	
17. Color of stools light brown or yellow	
18. Greasy or high fat foods cause distress	
19. Pain between shoulder blades	
20. Dark circles under eyes	
21. "Acid" breath	
22. History of gallbladder attacks or gallstones OR gallbladder removed YES ○ NO ○	
23. Appetite reduced	
Section C:	
24. Coated tongue or "fuzzy" debris on tongue	
25. Pass large amounts of foul smelling gas	
26. Irritable bowel or mucous colitis	
27. Constipation, diarrhea alternating or stools alternate from soft to watery	
28. Bowel movements painful or difficult constipation and/or laxatives used	
29. Burning or itching anus	

CATEGORY II

Section A:	
30. Head congestion/sinus fullness	
31. Sneezing attacks	
32. Dreaming, nightmare-like bad dreams	
33. Milk products and/or wheat products cause distress	
34. Eyes and nose watery	
35. Eyes swollen and puffy	
36. Pulse speeds after meals and/or heart pounds after retiring	

CATEGORY III

Section A:	
37. Crave sweets or coffee in afternoon or mid morning	
38. Hungry between meals or excessive appetite	
39. Overeating sweets	
40. Eat when nervous	
41. Irritable before meals	
42. Get "shaky" or light-headed if meals delay	
43. Fatigue, eating relieves	
44. Heart palpitates if meals missed or delayed	
45. Awaken a few hours after sleep, hard to get back to sleep	
Section B:	
46. Muscle soreness after moderate exercise	
47. Vulnerability to insect bites (especially fleas and mosquitoes)	
48. Loss of muscle tone or "heaviness" in arms or legs	
49. Enlarged heart and/or heart failure	
50. Worrier, feel insecure and/or heart failure	
51. Pulse slow/below 65 or irregular pulse YES ○ NO ○	

CATEGORY IV

Section A:	
52. Sex drive increased	
53. "Splitting" type headaches	
54. Memory failing	
55. Tolerance for sugar reduced	
Section B:	
56. Sex drive reduced or absent	
57. Abnormal thirst	
58. Weight gain around hips or waist	
59. Tendency to ulcers or colitis	
60. Increased ability to eat sugar without symptoms	
61. Menstrual disorders (women)	
62. Lack of menstruation (young girls)	
Section C:	
63. Difficulty gaining weight, even if large appetite	
64. Heart palpitations	
65. Nervous, emotional, and/or can't work under pressure	
66. Insomnia	
67. Inward Trembling	
68. Night Sweats	
69. Fast pulse at rest	
70. Intolerant to high temperatures	
71. Easily flushed	

KEY			
0 = N/A (Not Applicable/Never)	1 = Mild (Occurs once a month or less)	2 = Moderate (Occurs several times a month)	3 = Severe (Aware of it almost constantly)

Section D:	
72. Difficulty losing weight	
73. Reduced initiative and/or mental sluggishness	
74. Easily fatigued, sleepy during day	
75. Sensitive to cold, poor circulation (cold hands/feet)	
76. Dry or scaly skin	
77. "Ringing" in ears/noises in head	
78. Hearing impaired	
79. Constipation	
80. Excessive falling hair and/or coarse hair	
81. Headaches when awaken/wear off during day	
Section E:	
82. Blood pressure increased	
83. Headaches	
84. Hot flashes	
85. Hair growth on face or body (Question to females)	
86. Masculine tendencies (Question to female)	
Section F:	
87. Blood pressure low	
88. Crave salt	
89. Chronic fatigue/get drowsy	
90. Afternoon yawning	
91. Weakness/dizziness	
92. Weakness after colds/slow recovery	
93. Circulation poor	
94. Muscular and nervous exhaustion	
95. Subject to colds, asthma, bronchitis (respiratory disorders)	
96. Allergies and/or hives	
97. Difficulty maintaining manipulative correction	
98. Arthritic tendencies	
99. Nails weak, ridged	
100. Perspire easily	
101. Slow starter in morning	
102. Afternoon headaches	

CATEGORY V

Section A:	
103. Frequent skin rashes and/or hives	
104. Muscle-leg-toe cramping at rest and/or while sleeping	
105. Fever easily raised/levers common	
106. Crave Chocolate	
107. Feet have bad odor	
108. Hoarseness frequent	
109. Difficulty swallowing	
110. Joint stiffness after rising	
111. Vomiting frequent	
112. Tendency to anemia	
113. "Whites" of eyes (sciera) blue	
114. "Lump" in throat	

CATEGORY V

Section A: Cont'd	
115. Dry mouth-eyes-nose	
116. White spots on finger nails	
117. Cuts heal slowly and/or scar easily	
118. Reduced or "lost" sense of taste and/or smell	
119. Susceptible to colds, fevers, and/or infections	
120. Strong light irritates eyes	
121. Noises in head or ringing in ears	
122. Burning sensations in mouth	
123. Numbness in hands and feet (extremities go to sleep)	
124. Intolerant to monosodium glutamate (MSG)	
125. Cannot recall dreams	
126. Nose bleeds frequent	
127. Bruise easily, "black and blue" spots	
128. Muscle cramps, worse with exercise (charley horses)	

CATEGORY VI

Section A:	
129. Aware of heavy and/or irregular breathing	
130. Discomfort in high altitudes	
131. "Air hunger"/sigh frequently	
132. Swollen ankles/worse at night	
133. Shortness of breath with exertion	
134. Dull pain in chest and/or pain radiating into left arm, worse on exertion	

CATEGORY VII - Female Only

Section A:	
135. Premenstrual tension	
136. Painful menses (cramping, etc.)	
137. Menstruation excessive or prolonged	
138. Painful/tender breasts	
139. Menstruate too frequently	
140. Acne, worse at menses	
141. Depressed feeling before menstruation	
142. Vaginal discharge	
143. Menses scanty or missed	
144. Hysterectomy/ovaries removed	
145. Menopausal hot flashes	
146. Depression	

CATEGORY VIII - Male Only

Section A:	
147. Prostate trouble	
148. Urination difficult or dribbling	
149. Night urination frequent	
150. Pain on inside of legs or heels	
151. Feeling of incomplete bowel evacuation	
152. Leg nervousness at night	
153. Tire easily/avoid activity	
154. Reduced sex drive	
155. Depression	
156. Migrating aches and pains	

Dr. Carlos Santo, NMD
14200 N. Northsight Blvd, #160
Scottsdale, AZ 85260
480-213-8883

Consent for Consultation

I understand that Dr. Carlos Santo, through CLS-517, LLC is performing consulting services and that these services are strictly adjunctive to my ongoing health care provided by my primary care physician. I agree to present accurate and up to date records, to be renewed on an annual basis, from my primary care physician to Dr. Santo. Finally, I acknowledge and agree that I am required to have an annual exam that demonstrates that I am cancer-free and am cleared to seek bio-identical hormone therapy. For men this includes a digital rectal exam and a blood test for prostate-specific antigen (PSA), and for women, a thorough gynecological exam. All records must be faxed directly to Dr. Santo's office at 602-916-1650.

I agree to inform Dr. Santo immediately of any and all condition(s) I am suffering from, and/or if I am taking any prescriptions or over-the-counter medications. I agree to notify Dr. Santo immediately if I am or become pregnant, suspect I am pregnant, or am breast-feeding.

I acknowledge that as with any medical intervention, there are always potential health risks to treatment with hormone modulation.

I understand that records will be kept of the health services provided to me. These records will be kept confidential and will not be released to others unless so directed by myself or unless required by law.

I understand that results are never guaranteed. I do not expect Dr. Santo to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the aforementioned diagnostic and therapeutic procedures.

I intend for this consent to be active during the entire course of my working relationship with Dr. Santo and CLS-517, LLC. I understand that I am free to withdraw my consent and to discontinue this consulting relationship at any time. I further release Dr. Santo and CLS-517, LLC from any liability, miscommunication, or misunderstanding of information shared between parties and waive my right to pursue legal action should adverse side-effects occur as a result of this consulting relationship.

I understand that Dr. Santo may, in the course of this relationship, prescribe certain medications including but not limited to bio-identical hormones, thyroid medications, and/or adjunctive medications for further protocol support and success. I understand that Dr. Santo may also advise the use of nutritional supplements to compliment these prescriptions.

I understand that, though Dr. Santo does not have financial interest, nor is employed by any pharmacy, he may direct or suggest to me particular pharmacies based on locale or specificity of treatment. I acknowledge that I may choose to patronize any pharmacy of my choice.

I understand the aforementioned information and requirements and agree to proceed with all consultation services performed by Dr. Carlos Santo.

Patient Name: (Please Print): _____

Signature of Patient or Guardian: _____

Date: _____

_____