IVAN RUSILKO
LIFESTYLE MEDICINE

NEW PATIENT QUESTIONNAIRE

Full Name: _____

Email: _____

Cell Phone number: _____ Alternate Phone number: _____

Home Address: International Address (if applicable):

_____ _____

_____ _____

_____ _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Driver's License Number: _____ OR Social Security Number: _____
State issued: _____

What are your three main goals for treatment?

1. _____
2. _____
3. _____

Have you seen an Anti-Aging practitioner/physician before? _____ If yes, who? _____

If yes, what treatments/programs were prescribed? _____
Previous Hormone Treatments: _____

What made you decide to consult with Dr. Rusilko? _____

Did someone refer you? ____ Referral: _____

Do you consider your life stressful? _____ If yes, please describe: _____
_____

What is your occupation? _____ Do you travel often? YES NO

Current prescribed medications: _____
_____

Current over the counter medications: _____
_____

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Current vitamins/supplements:_____
_____

Current Medical conditions:

High Cholesterol	Anemia	Reflux/GERD
High Blood Pressure	Cancer	Prostate Enlargement/BPH
Heart Disease/Angina	Type_____	Pulmonary/Respiratory
Stroke	Treatment _____	Disorders/Asthma
Allergies/Eczema	Chronic Fatigue	Osteoporosis/Osteopenia
Thyroid Disease	Type 1 Diabetes	Neurological Disorders
Autoimmune Disorder	Type 2 Diabetes	Major Depression
Type _____	Hepatitis	Anxiety
Rheumatoid Arthritis	Gout	Other _____
Arthritis/Osteoarthritis	Digestive Disorders	

Have you noticed a change in the health of your hair, skin, or nails? YES NO
If yes, please describe: _____

Have you taken any steroids in the last 30 days? (e.g. testosterone, prednisone, cortisone)? YES NO
If yes, please describe: _____

Allergies: _____

Past Medical conditions (difficult pregnancies, hospitalizations, major illness):_____
_____

Past Surgeries:_____
_____

Family History (parents, siblings) - please check all appropriate boxes:

High Cholesterol	Rheumatoid Arthritis	Chronic Fatigue
High Blood Pressure	Arthritis/Osteoarthritis	Digestive Disorders
Heart Disease/Angina	Cancer	Prostate Enlargement/BPH
Stroke	Type_____	Pulmonary/Respiratory
Thyroid Disease	Treatment _____	Disorders/Asthma
Autoimmune Disorder	Type 1 Diabetes	Neurological Disorders
Type _____	Type 2 Diabetes	Other _____

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Do you smoke? YES NO If yes, how often? _____

Do you drink alcohol? YES NO If yes, how much and how often? _____

Do you consume any form of caffeine? YES NO If yes, how much and how often? _____

Are you on a special diet? YES NO If yes, please describe: _____

_____

How many times a day do you eat? ____ How much water do you drink per day? _____

How often do you exercise? REGULARLY OCCASSIONALLY RARELY NEVER

How many times a week do you exercise? _____

What do you typically do for exercise? (running, yoga, biking, weight training) _____

_____

How many hours of sleep do you get each night? _____

Would you consider it restful sleep? YES NO SOMETIMES

Do you have trouble falling asleep or staying asleep? YES NO SOMETIMES

Do you wake up tired? YES NO SOMETIMES What is your energy level? _____

How would you describe your overall sexual health? _____

Do you have any issues with memory or concentration? _____

_____

Do you have pain anywhere? YES NO If yes, please explain: _____

_____

Are you opposed to injections as part of your treatment plan? YES NO

I fully understand that no insurance is accepted at Lifestyle Medicine and you agree to not seek reimbursement for any treatments, labs, or medications from any third-party insurance company. This is a private pay practice.

I consent to treatment with the understanding and knowledge that no insurance will be accepted or reimbursed.

I understand that all billing done by Lifestyle medicine is done in packages which include all treatments, medications, , follow up and plan formations.

Signature: _____ Date: _____

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For your convenience we accept cash, check, MasterCard, American Express, and Visa. Wire transfers are also accepted but a confirmed transfer is required before programs are discussed, tests are initiated or a treatment plan is engaged.

If you choose to pre-authorize credit card payments, invoices will be issued via email to patient and fees will be collected at the time of engagement for any program or medical services rendered. Credit cards will be kept on file for convenience for the duration of your program.

CREDIT CARD AUTHORIZATION

IMPORTANT: A SEPARATE FORM MUST BE COMPLETED FOR EACH PRE-AUTHORIZED CREDIT CARD

Patient Name: _____

Mailing Address_____

City _____ State _____ Zip_____ Country _____

Credit Card Type: AMERICAN EXPRESS VISA MASTERCARD

Name on Credit Card _____

_____

CREDIT CARD ACCOUNT NUMER EXPIRATION DATE SECURITY CODE

Billing Address _____

City _____ State _____ Zip_____ Country _____

I AUTHORIZE DR. IVAN RUSILKO LIFESTYLE MEDICINE (DR IVAN RUSILKO ENTITIES) TO KEEP MY SIGNATURE ON FILE AND TO CHARGE MY _____ ACCOUNT FOR RECURRING CHARGES (ON-GOING TREATMENTS) ACCORDING TO INVOICE.

VISA, MASTERCARD, AMEX

I UNDERSTAND THAT THIS FORM IS VALID UNTIL THE CARD EXPIRES UNLESS I CANCEL THROUGH WRITTEN NOTICE TO THE HEALTH CARE PROVIDER.

SIGNATURE: _____ Date: ___ / ___ / _____

Please return completed form to DrIvanAssist@LFSTM.com along with the other New Patient paperwork prior to your first appointment after the initial consult. If you have any questions, please call the office – **786-334-3664** or email DrIvanAssist@LFSTM.com.

REV JANUARY 2019