

Renaissance Medical Center

Daniela Paunesky, MD
Anti-Aging, Internal Medicine, and Weight Loss
11300 Atlantis Place Ste. A, Alpharetta GA 30022
Phone (770) 777-7707/Fax (770) 777-7789

Patient Registration

Patient Personal Information

Sex: Male Female

Marital Status: Single Married Divorced Widowed

Name _____
Last Name First Name Initial

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone Number _____

Pharmacy Phone Number _____

Social Security # _____ DOB _____

Patient/Responsible Party Information

Responsible Party _____ DOB _____

Relationship to Patient: SELF SPOUSE OTHER _____ Social Security # _____

Responsible Party's Home Phone _____ Work Phone () _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Referral Information: Referred by _____

Emergency Contact

Name of person not living with you _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home () _____ Work () _____

Renaissance Medical Center
Daniela Paunesky, MD
Anti-Aging, Internal Medicine, and Aesthetics
11300 Atlantis Place Ste. A, Alpharetta GA 30022
Phone (770) 777-7707/Fax (770) 777-7789

Patient's Health Survey
CONFIDENTIAL INFORMATION

Please complete all sections of this form as completely as possible.

Date of exam _____

Name _____
Last Name First Name Middle Initial

Would you prefer most follow-up appointments to be done by phone or as visits to the office? _____

Previous or Current Healthcare Providers

Name _____ Specialty _____

Phone Number _____ Fax _____

Name _____ Specialty _____

Phone Number _____ Fax _____

Name _____ Specialty _____

Phone Number _____ Fax _____

Name _____ Specialty _____

Phone Number _____ Fax _____

Name _____ Specialty _____

Phone Number _____ Fax _____

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Family History
CONFIDENTIAL INFORMATION

Please provide as much information as possible on each of the relatives listed.

Father & Mother

| | Age | Health-excellent or poor | Age of Death | Cause of Death |
|--------|-----|--------------------------|--------------|----------------|
| Father | | | | |
| Mother | | | | |

Siblings # of siblings _____

| | Age | Health-excellent or poor | Age of Death | Cause of Death |
|-----|-----|--------------------------|--------------|----------------|
| M F | | | | |
| M F | | | | |
| M F | | | | |
| M F | | | | |
| M F | | | | |

Spouse

| | Age | Health-excellent or poor | Age of Death | Cause of Death |
|-----|-----|--------------------------|--------------|----------------|
| M F | | | | |

Children # of children _____

| | Age | Health-excellent or poor | Age of Death | Cause of Death |
|-----|-----|--------------------------|--------------|----------------|
| M F | | | | |
| M F | | | | |
| M F | | | | |
| M F | | | | |

Grandparents-Father's Parents

| | Age | Health-excellent or poor | Age of Death | Cause of Death |
|--------|-----|--------------------------|--------------|----------------|
| Father | | | | |
| Mother | | | | |

Grandparents-Mother's Parents

| | Age | Health-excellent or poor | Age of Death | Cause of Death |
|--------|-----|--------------------------|--------------|----------------|
| Father | | | | |
| Mother | | | | |

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself & indicate which relatives (if any) have had any of the following.

| | | | Yourself | | Relatives Who |
|---------------------------|-----|----|----------|-----------|------------------|
| | Yes | No | Type | When/Date | |
| Allergies | Yes | No | | | |
| Anemia | Yes | No | | | |
| Bone/Joint Disease | Yes | No | | | |
| Asthma | Yes | No | | | |
| Cancer | Yes | No | | | |
| Neuritis/Neuralgia | Yes | No | | | |
| Encephalitis | Yes | No | | | |
| Epilepsy | Yes | No | | | |
| Frequent Cold/Sore Throat | Yes | No | | | |
| Goiter (Enlarged Thyroid) | Yes | No | | | |
| Gout | Yes | No | | | |
| Hay Fever | Yes | No | | | |
| Heart Trouble | Yes | No | | | |
| Hepatitis A | Yes | No | | | |
| Hepatitis B | Yes | No | | | |
| Hepatitis C | Yes | No | | | |
| High Blood Pressure | Yes | No | | | |
| Low Blood Pressure | Yes | No | | | |
| Polio | Yes | No | | | |
| Migraine Headaches | Yes | No | | | |
| Nervous Breakdown | Yes | No | | | |
| Diabetes | Yes | No | | | |
| Rheumatic Fever | Yes | No | | | |
| Shingles | Yes | No | | | |
| Stroke | Yes | No | | | |
| Tuberculosis | Yes | No | | | |
| Syphilis | Yes | No | | | |
| Yellow Jaundice | Yes | No | | | |

Other Illnesses (explain): _____

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History-Medication/Drugs
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

| Drugs/Medications | Never | Occasionally | Frequently | Daily |
|---|--------------|---------------------|-------------------|--------------|
| Laxatives | Never | Occasionally | Frequently | Daily |
| Vitamins | Never | Occasionally | Frequently | Daily |
| Sedatives | Never | Occasionally | Frequently | Daily |
| Sleeping Pills, etc. | Never | Occasionally | Frequently | Daily |
| Aspirins, etc. | Never | Occasionally | Frequently | Daily |
| Thyroid | Never | Occasionally | Frequently | Daily |
| Appetite Depressants | Never | Occasionally | Frequently | Daily |
| Antihistamines | Never | Occasionally | Frequently | Daily |
| Birth Control Pills | Never | Occasionally | Frequently | Daily |
| Have you ever been treated for drug habits? | Never | Occasionally | Frequently | Daily |
| Have you ever taken insulin tablets? | Never | Occasionally | Frequently | Daily |
| Have you ever taken blood pressure medicine? | Never | Occasionally | Frequently | Daily |
| Are you allergic to any drugs or medications? | Never | Occasionally | Frequently | Daily |
| Nitroglycerine | Never | Occasionally | Frequently | Daily |
| Diuretics/Water Pills | Never | Occasionally | Frequently | Daily |
| Antibiotics | Never | Occasionally | Frequently | Daily |
| Anticoagulants | Never | Occasionally | Frequently | Daily |
| Coffee | Never | Occasionally | Frequently | Daily |
| Tea | Never | Occasionally | Frequently | Daily |

| Alcohol | Age Begun | Amount per week for last 5 years | Age Stopped | # Years Drink |
|----------------|------------------|---|--------------------|----------------------|
| Wine | | | | |
| Beer | | | | |
| Hard Liquor | | | | |
| Cigarettes | | | | |

Hormone Replacement Therapy or Steroid Therapy

Past _____ Present _____

List _____

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History-Examinations & Medications
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

Please list current medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list medications used in the past.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list previous examinations.

| Examination | Year | Normal | Abnormal |
|-------------------------|------|--------|----------|
| Chest X-ray | | Normal | Abnormal |
| GI X-ray | | Normal | Abnormal |
| Other X-ray | | Normal | Abnormal |
| Electrocardiogram (EKG) | | Normal | Abnormal |
| Mammogram | | Normal | Abnormal |
| Blood | | Normal | Abnormal |
| Eye | | Normal | Abnormal |
| Prostate Exam (Men) | | Normal | Abnormal |
| Gynecology (Women) | | Normal | Abnormal |
| Pap Smear (Women) | | Normal | Abnormal |
| General Check-up | | Normal | Abnormal |

Please list what year you have had these immunizations if you have had them in the last 3 years:

Hepatitis _____ Flu _____ PPD or Tine Test _____ Other _____

Serious Illnesses, Operations, Injuries: List in order starting from most recent.

| <u>Type of Illness, Operation, or Injury</u> | <u>Year</u> | <u>Name & Location of Hospital for Treatment</u> |
|--|-------------|--|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History-Systematic Review
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

Skin

| | | | | |
|---|-----|----|-----|------|
| Persistent rash on skin | Yes | No | Now | Past |
| Skin allergy of Hives | Yes | No | Now | Past |
| Skin infections or skin diseases | Yes | No | Now | Past |
| Exposed to strong chemicals or poisons | Yes | No | Now | Past |
| Unusual falling out of hair | Yes | No | Now | Past |
| Sore that does not heal | Yes | No | Now | Past |
| Unusual prolonged bleeding from cuts or wounds | Yes | No | Now | Past |
| Really black (not brown) moles anywhere on skin | Yes | No | Now | Past |
| Any skin blemish increasing in size | Yes | No | Now | Past |

Cardiovascular System

| | | | | |
|--|-----|----|-----|------|
| Have you ever had any high blood pressure, heart trouble, or heart murmur? | Yes | No | Now | Past |
| Have you ever been awakened in the middle of the night with chest pain or shortness of breath? | Yes | No | Now | Past |
| Do you ever have chest pain when moving arms, bending, turning, coughing, lying down, or deep breathing? | Yes | No | Now | Past |
| After climbing stairs or walking, do you have to stop because of chest pains or shortness of breath? | Yes | No | Now | Past |
| Have you ever had severe chest pain behind the breastbone, radiating to the shoulder, jaw, hand, or abdomen? | Yes | No | Now | Past |
| Do you ever have severe chest pain after eating, belching, prolonged walking or emotional upset? | Yes | No | Now | Past |
| Does your heart often skip a beat or race? | Yes | No | Now | Past |
| Have you noticed any ankle swelling? | Yes | No | Now | Past |
| Do you have leg cramps when walking or resting? | Yes | No | Now | Past |
| In cold weather or cold water, do you have pain in your fingers or toes? | Yes | No | Now | Past |

Additional Information:

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History-Systematic Review Continued
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

Neurological System

| | | | | |
|--|-----|----|-----|------|
| Frequent headaches | Yes | No | Now | Past |
| Headaches associated with pain and pulsation of blood vessels in temples | Yes | No | Now | Past |
| Dizziness when turning your head quickly | Yes | No | Now | Past |
| Dizziness associated with whistling sound, nausea, or difficulty in hearing | Yes | No | Now | Past |
| Headaches with tightness in neck and scalp muscles, with sensation of tight band around the head | Yes | No | Now | Past |
| Any part of your body ever been paralyzed | Yes | No | Now | Past |
| Some impairment of your arms, legs, or hands due to a shaking tremor or spasm | Yes | No | Now | Past |
| Bothered by not being able to speak distinctly | Yes | No | Now | Past |
| Tingling feeling in your fingers or toes | Yes | No | Now | Past |

Endocrine System

| | | | | |
|--|-----|----|-----|------|
| Persistent recurring pains in any part of your body | Yes | No | Now | Past |
| Unduly sensitive to heat or cold | Yes | No | Now | Past |
| Any thyroid trouble | Yes | No | Now | Past |
| Weight loss of more than 10 pounds in the last 6 months | Yes | No | Now | Past |
| Weight increase of more than 10 pound in the last 6 months | Yes | No | Now | Past |
| Weight constant the last 5 years | Yes | No | Now | Past |

Additional Information:

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History-Systematic Review Continued
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

Gastrointestinal System

| | | | | |
|---|-----|----|-----|------|
| Trouble swallowing or does food stick midway down | Yes | No | Now | Past |
| Gnawing pain or burning in the pit of your stomach, between meals or in the middle of the night | Yes | No | Now | Past |
| Vomited blood, bile or passed black tarry stools (color of shoe polish) | Yes | No | Now | Past |
| Stomach distress that keeps you from eating certain foods (spicy, fried, coffee, alcohol) | Yes | No | Now | Past |
| Stomach distress relieved by milk, food, or bicarbonate | Yes | No | Now | Past |
| Common for you to feel weak or break into a sweat a few hours after eating | Yes | No | Now | Past |
| Suffer often from heartburn, indigestion, or gas | Yes | No | Now | Past |
| Eat in a hurry or at irregular times | Yes | No | Now | Past |
| Any recent change in your bowel habit | Yes | No | Now | Past |
| Frequent bowel movements that are large, pasty, float on water and have an unusual odor | Yes | No | Now | Past |
| Frequent, loose bowel movements (with or without blood or mucus) | Yes | No | Now | Past |
| Piles (hemorrhoids) or notice bright red blood with bowel movements | Yes | No | Now | Past |
| Constipated (2 or more days without a bowel movement) | Yes | No | Now | Past |
| Pain or itch in your rectum | Yes | No | Now | Past |
| Noticed pus or abscess at the base of your spine | Yes | No | Now | Past |

Urinary Tract System

| | | | | |
|---|-----|----|-----|------|
| Kidney or bladder infections | Yes | No | Now | Past |
| Swelling or puffiness around eyes or face | Yes | No | Now | Past |
| Sugar in urine | Yes | No | Now | Past |
| Protein or albumin in urine | Yes | No | Now | Past |
| Passed blood in urine | Yes | No | Now | Past |
| Frequent urination at night | Yes | No | Now | Past |
| Any pain during urination | Yes | No | Now | Past |
| Trouble stopping the urine stream (dribbling) | Yes | No | Now | Past |
| Trouble starting or maintaining force of urine stream | Yes | No | Now | Past |
| Difficulty in holding your urine | Yes | No | Now | Past |
| Back pains related to urinating | Yes | No | Now | Past |

Additional Information:

Renaissance Medical Center
 Daniela Paunesky, MD
 Anti-Aging, Internal Medicine, and Aesthetics
 11300 Atlantis Place Ste. A, Alpharetta GA 30022
 Phone (770) 777-7707/Fax (770) 777-7789

Medical History-Review
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself in reference to the last year.

| | | | |
|--------------------------------|----------|----------|-----------|
| Percentage of body fat | Increase | Decrease | No Change |
| Aerobic capacity | Increase | Decrease | No Change |
| Energy level | Increase | Decrease | No Change |
| Vision | Increase | Decrease | No Change |
| Hearing | Increase | Decrease | No Change |
| Bone Density | Increase | Decrease | No Change |
| Skin turgor (wrinkles/sagging) | Increase | Decrease | No Change |
| Allergy | Increase | Decrease | No Change |
| Episodes of infections/flu | Increase | Decrease | No Change |
| Hair loss | Increase | Decrease | No Change |
| Libido (sexual drive) | Increase | Decrease | No Change |
| Frequency of sex | Increase | Decrease | No Change |
| Endurance | Increase | Decrease | No Change |
| Memory | Increase | Decrease | No Change |
| Immunity | Increase | Decrease | No Change |

| | | |
|-------------------------------------|---------|--------|
| Edema (swelling) around eyes | Present | Absent |
| Hoarseness of voice | Present | Absent |
| Peripheral edema (swelling) of legs | Present | Absent |
| Decreased sweating | Present | Absent |
| Dry skin | Present | Absent |
| Crying spells | Present | Absent |
| Dizzy, faint, or shaky | Present | Absent |
| Irritable or angry | Present | Absent |
| Mood changes | Present | Absent |
| Sad, depressed | Present | Absent |
| Skin eruptions | Present | Absent |
| Sleep alterations | Present | Absent |
| Tense, nervousness | Present | Absent |

Additional Information:

Medical History-Review Continued
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

Digestive System

| | | | | |
|---|-----|-------|-------|--------|
| Have you ever had a stool checked for parasites? | Yes | No | Date | Result |
| Have you ever been treated for a parasite infection? | Yes | No | Date | Result |
| Do you take digestive enzymes daily? | Yes | No | | |
| Do you take Psyllium products (like Metamucil)? | Yes | No | Daily | |
| Skin problems? | Dry | Itchy | Acne | Other |
| Cuts or bruises heal slowly? | Yes | No | | |
| Subject to frequent colds and infections? | Yes | No | | |
| Poor concentration? | Yes | No | | |
| Strong desire for sweet or salty foods? | Yes | No | | |
| Difficulty getting up in the morning? | Yes | No | | |
| Often feel bloated? | Yes | No | | |
| Frequent bowel gas? | Yes | No | | |
| Weak fingernails/unhealthy hair? | Yes | No | | |
| Water retention? | Yes | No | | |
| How many glasses of water do you drink per day? | | | | |
| How many meals do you eat per day? | | | | |
| How many bowel movements do you have per day or per week? | | | | |

Female Menstrual History

| | | | |
|---|-------|----|--|
| When was your last normal menses? | Date: | | |
| Are you spotting occasionally? | Yes | No | |
| Have you ever had an endometrial biopsy? | Yes | No | |
| | Date: | | |
| Have you ever had a transvaginal ultrasound? | Yes | No | |
| | Date: | | |
| Are your menses irregular? | Yes | No | |
| Have your menses ever been regular off any hormone replacement therapy or birth control pill? | Yes | No | |

Additional Information:

Medical History-Review Continued
CONFIDENTIAL INFORMATION

Please provide as much information as possible on yourself.

Sleep Review

Do you feel excessively sleepy in the daytime? Yes No

If yes, how long have you been feeling sleepy in this way? _____ months/years

Do you feel that your sleepiness is a result of poor quality nighttime sleep? Yes No Possibly

Do you fall asleep unintentionally while (circle the most accurate)

| | | | | |
|--------------|-------|--------------|------------|--------|
| Reading | Never | Occasionally | Frequently | Always |
| Watching TV | Never | Occasionally | Frequently | Always |
| Conversation | Never | Occasionally | Frequently | Always |
| Meals | Never | Occasionally | Frequently | Always |
| Work | Never | Occasionally | Frequently | Always |
| Driving | Never | Occasionally | Frequently | Always |

Have you ever had an accident or near miss accident because of falling asleep driving? Yes No

Do you snore? Yes No

If so, how often? Occasionally Frequently Always

Please circle "loudness" rating of snoring below

| | | | | | | | | | | | | |
|--------------------|---|---|---|---|---|---|---|---|---|---|----|----------------------|
| Patient's rating | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very loud/disturbing |
| Bed partner rating | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very loud/disturbing |

With snoring, do you have any episodes of

| | | |
|--|-----|----|
| Choking/gagging | Yes | No |
| Episodes of stopping breathing | Yes | No |
| Awakenings | Yes | No |
| A bed partner noting that you stopped breathing during sleep | Yes | No |
| Usually awakening with a dry mouth or sore throat | Yes | No |
| Napping during the day | Yes | No |
| Refreshment after your naps | Yes | No |

Answer the following questions assuming "night" means your major sleep time.

| | | |
|---|-----|----|
| Do you often have trouble getting to sleep at night? | Yes | No |
| What is the average number of minutes it takes you to fall asleep at night? | | |
| Do you often have awakenings during the night? | Yes | No |
| What is the average number of times per night that you wake up? | | |
| If yes, why do you awaken? | | |

Additional Information:

Questionnaire

Patient: _____

Date: _____

Please rate the following questions according to a scale from 1-10:

Never = 0-2

Often = 3-5

Much of the time = 6-9

All the time = 10

- | | | | | |
|--|-----------------------------|-----------------------------|--|------------------------------------|
| 1. How often do you feel sad? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 2. How often do you think pessimistically? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 3. How often do you see failures in your life? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 4. How often do you feel a loss of pleasure? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 5. How often do you feel guilty or have guilty feelings? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 6. How often do you feel you're being punished? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 7. How often do you not like yourself? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 8. How often are you self-critical about yourself in a negative way? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 9. How often do you have suicidal thoughts? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 10. How often do you cry? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 11. How often do you feel agitated or irritated? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 12. How often do you feel a loss of interest in people or other aspects of your life? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 13. Do you ever have trouble making decisions? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 14. Do you ever have feelings of worthlessness? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 15. Have you felt a loss of energy? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 16. Have you felt any changes in your appetite? Describe: _____ | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 17. Have you had any difficulty with concentration? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 18. Have you had any changes in the way you feel tired or fatigued? Describe: _____ | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |
| 19. Have you felt a loss of interest in sex or decreased libido? | <input type="radio"/> never | <input type="radio"/> often | <input type="radio"/> much of the time | <input type="radio"/> all the time |

Renaissance Medical Center
Daniela Paunesky, MD
Anti-Aging, Internal Medicine, and Aesthetics
11300 Atlantis Place Ste. A, Alpharetta GA 30022
Phone (770) 777-7707/Fax (770) 777-7789

History & Medical Review Completion
CONFIDENTIAL INFORMATION

What are your goals in visiting the doctor? What do you want to accomplish?_____

I affirm that I have answered the questions to the history and medical review to my best possible knowledge by signing below.

Patient Name

Date

Patient Signature

Date