

Medical History Form*Denise E. Bruner, M.D. & Associates, P.C.***NAME:**(LAST)

(FIRST)

(M.I.)

DATE OF BIRTH: _____ / _____ / _____

SEX: M / F

AGE:

MARITAL STATUS: (PLEASE CIRCLE ONE)

S

M

W

D

MEDICATION ALLERGIES**ADDRESS**

(STREET) _____

(CITY) _____

(STATE) _____

(ZIP) _____

PHONE NUMBERS

HOME: _____

WORK: _____

CELL: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

OCCUPATION: _____

REFERRED BY: _____

FAMILY PHYSICIAN: _____

FAMILY PHYSICIAN PHONE NUMBER: _____

EMERGENCY CONTACT

RELATIONSHIP: _____

PHONE NUMBER: _____

NOTES/ADDITIONAL INFO: _____

May We Contact You By **Phone**?

Yes

No

May We Contact You Via **E-MAIL**?

Yes

No

May We **MAIL** You Appointment Reminders?

Yes

No

REASON FOR INITIAL VISIT Weight Management Hormone Therapy IV/Vitamin Therapy B12 Injections Mesotherapy Laser Botox/Fillers Other: _____

Medical History Form*Denise E. Bruner, M.D. & Associates, P.C.***PRESENT STATUS**

1. Are you under a doctor's care at the present time? Yes No

2. If yes, for what?

MEDICATIONS1. Please list any medications you are taking at the present time, including vitamins/supplements:
(IF YOU NEED ADDITIONAL SPACE, PLEASE USE THE *NOTES SECTION ON THE NEXT PAGE)

Medication

Dosage

Frequency

Start Date

2. Please list any allergies to medications:

Medication

Reaction

PAST MEDICAL HISTORY

Please indicate date of diagnosis or when symptoms first appeared next to all that apply:

- | | |
|--|---|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Indigestion/Gas |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Insulin resistance |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Irritable bowel |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Psychiatric / Mental illness |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Gum disease | <input type="checkbox"/> Ulcer disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> High cholesterol | |

Medical History Form*Denise E. Bruner, M.D. & Associates, P.C.***PAST MEDICAL HISTORY** (CONTINUED)

Please list any surgeries, hospitalizations or serious illnesses, starting with the most recent:

DATE	SURGERY•HOSPITALIZATION•ILLNESS	LOCATION•HOSPITAL

FAMILY HISTORY

Have any blood relatives ever had any of the following?

DISEASE	YES	NO	FAMILY MEMBER(S)
Depression	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____
Heart Disease/Stroke	Yes	No	Who? _____
High Blood Pressure	Yes	No	Who? _____
Overweight/Obesity	Yes	No	Who? _____
Cancer	Yes	No	Who? _____
Thyroid disease	Yes	No	Who? _____
Other: _____	Yes	No	Who? _____

***NOTES** PLEASE INCLUDE ANY ADDITIONAL INFO YOU FEEL THE DOCTOR SHOULD KNOW**THE INFORMATION CONTAINED IN THIS DOCUMENT IS ACCURATE TO THE BEST OF MY KNOWLEDGE,**

PATIENT SIGNATURE: _____ DATE: _____

NAME (PRINT): _____ D.O.B. _____ DATE: _____

Medical History Form

Denise E. Bruner, M.D. & Associates, P.C.

NUTRITIONAL EVALUATION

1. Tell us about your weight:

Present Weight: _____ Lbs.

Desired Weight: _____ Lbs.

Weight 1 year ago: _____ Lbs.

Weight at age 20: _____ Lbs. (YEAR) _____

MAXIMUM LIFETIME WEIGHT (NON-PREGNANT)

_____ Lbs. (YEAR) _____

2. When did you begin gaining excess weight? (give reasons, if known)

3. Please list any diets/weight loss plans you have tried in the past, starting with the most recent
Include date, plan, any medications/supplements and weight lost.

DATE

PLAN

MEDICATIONS

LBS. LOST

4. Is your spouse or partner overweight? Yes No

5. By how much is he or she overweight? Yes No

6. How often do you eat out? _____

7. Who plans your meals? _____

Who cooks? _____

Who shops? _____

8. Are there any foods you crave? Yes No

9. What specifically do you crave and when? _____

10. Do you awaken hungry during the night? Yes No

11. What do you do when you wake hungry? _____

12. When you experience stressful situations, do you tend to eat more? **Please explain:**

Medical History Form*Denise E. Bruner, M.D. & Associates, P.C.***NUTRITIONAL EVALUATION** (CONTINUED)**16.** Do you eat when you are bored? Yes No**17.** Smoking Habits (check only 1)

- You have never smoked cigarettes, cigars or pipes
- You quit smoking _____ years ago and have not smoked since
- You smoke _____ cigarettes a day

18. How many cups of water do you drink in 1 day? _____**19.** How many sodas do you drink in 1 day? _____**20.** Regular or diet soda? _____**21.** How many caffeinated beverages do you drink in 1 day? _____**22.** How frequently do you eat out for lunch? _____**23.** How frequently do you eat out for dinner? _____**24.** How frequently do you eat fast food? _____**25.** Please explain what you eat on a typical day. Use common measurements for amounts.
Include all beverages and snacks.**DIETARY INTAKE**

	TIME	WHERE	WITH WHOM	FOOD AND AMOUNT
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

ACTIVITY / EXERCISE**1.** What type of exercise do you do?

NONE

AEROBIC

RESISTANCE TRAINING

FLEXIBILITY TRAINING

OTHER

2. Please list your specific forms of exercise:**3.** How many times do you exercise each week?

NEVER

1-3

3-5

5-7

MORE THAN 7

4. When you exercise, how long are your exercise sessions?

15 - 30 MINUTES

30 - 45 MINUTES

45 - 60 MINUTES

60 - 75 MINUTES

75 - 90 MINUTES

90 MINUTES OR GREATER

Medical History Form

Denise E. Bruner, M.D. & Associates, P.C.

MEN

1. Please list the date of onset for any symptoms that apply:

Decreased erections/erectile dysfunction (DATE) _____

Decreased sex drive (DATE) _____

Moodiness (DATE) _____

Poor concentration (DATE) _____

Weight gain (DATE) _____

Increased frequency of urinating at night (DATE) _____

2. Have you ever been diagnosed with prostate cancer? Yes No

3. What was the date of your last PSA test? (DATE) _____

IS THERE ANYTHING ELSE THE DOCTOR SHOULD KNOW?

THE INFORMATION CONTAINED IN THIS DOCUMENT IS ACCURATE TO THE BEST OF MY KNOWLEDGE,

PATIENT SIGNATURE: _____ DATE: _____

NAME (PRINT): _____ D.O.B. _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

NAME (PRINT): _____ D.O.B. _____ DATE: _____

Please fill out and bring this form to your appointment, or fax it to us at (703) 558 - 4980, thank you!