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: ______

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PRESENT STATUS

1. Are you under a doctor's care at the present time? Yes No
2. If yes, for what?

MEDICATIONS

1. 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:

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

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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: ____________

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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**:

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

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WOMEN: GYNECOLOGIC HISTORY

Do you still have monthly periods? Yes No

Age at onset of menstruation: ____

First day of last menstrual period: ____

Duration of periods: ____

Are your periods regular? Yes No

Do you have painful or heavy periods? Yes No

Number of pregnancies, weight gain and complications:

When was your last PAP test? ____

When was your last mammogram? ____

When was your last Dexa scan (bone density measurement)? ____

Do you take any hormone replacement therapy (HRT)? Yes No

Name and dosage? ____

What is your method of contraception? ____

Are you having any symptoms of menopause or peri-menopause? Yes No

List date of onset for all that apply:

- ☐ Decreased sex drive ____
- ☐ Poor concentration/mental fog ____
- ☐ Forgetfulness ____
- ☐ Weight gain ____
- ☐ Sleep disturbances ____
- ☐ Irritability ____
- ☐ Hot flashes ____
- ☐ Infertility ____
- ☐ Premenstrual syndrome (PMSP) ____
- ☐ Polycystic Ovarian Syndrome (PCOS) ____
- ☐ Endometriosis ____

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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!