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

Medical History Form

DATE_____

NAME _____ DATE OF BIRTH _____
LAST FIRST M.I.

SEX M / F AGE_____ MARITAL STATUS S M W D

MEDICATION ALLERGIES_____

ADDRESS_____

_____

HOME PH (_____)_____WORK PH (_____)_____ CELL PH (_____)_____

EMAIL ADDRESS _____

EMPLOYER _____

OCCUPATION_____

REFERRED BY _____

FAMILY PHYSICIAN/ PH#_____

EMERGENCY CONTACT _____/_____

_____/_____
RELATIONSHIP

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	___Botox/Fillers	___Other _____

PRESENT STATUS

1. Are you currently under a doctor's care for a specific condition? ____YES ____NO
2. If yes, please list conditions for which you are being treated:_____

_____

_____

_____

Name _____ Date of Birth _____

MEDICATIONS

1. Please list any medications you are taking at the present time, including vitamins/supplements. If you need additional space, use the back of this page.

Medication	Dose	Frequency	Start Date

2. Please list any allergies to ***medications***:

Medication	Reaction

HEALTH HISTORY

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

DATE	**DATE**	**DATE**
_____Alcohol abuse	_____Gout	_____Kidney disease
_____Anemia	_____Gum disease	_____Liver disease
_____Arthritis	_____Headaches	_____Lung disease
_____Asthma	_____Heart attack	_____Osteoporosis
_____Autoimmune disorder	_____Heart disease	_____PCOS
_____Bleeding disorder	_____Hepatitis	_____Pneumonia
_____Cancer	_____High cholesterol	_____Psychiatric illness
_____Constipation	_____HIV	_____Sleep disorder
_____Chronic fatigue	_____Hypertension	_____Thyroid disease
_____Diabetes	_____Indigestion/Gas	_____Ulcer disease
_____Drug abuse	_____Infertility	_____Other
_____Eating disorder	_____Insulin resistance	_____
_____Fibromyalgia	_____Irritable bowel	_____
_____Gallbladder disease	_____Jaundice	_____

Name_____ Date of Birth_____

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

Date	Surgery/Hospitalization/Illness	Location/Hospital

3. Have any **blood** relatives ever had any of the following?

Condition	Yes	No	How related
Diabetes			
Heart Disease/Stroke			
Hypertension			
Obesity			
Cancer			
Thyroid Disease			

NUTRITIONAL EVALUATION

1. Tell us about your weight:

Current Weight	lbs.
Desired Weight	lbs.
Weight 1 year ago	lbs.
Weight at age 20	lbs.
Maximum lifetime weight (non-pregnant)	lbs.

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

Name_____ Date of Birth_____

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, fiancé´ or partner overweight? ____Yes ____No

5. By how much is he or she overweight?_____

6. Who plans meals?_____ Cooks?_____ Shops?_____

7. Are there any foods you crave? ____Yes____No

8. What and when?_____

9. Do you awaken hungry during the night? ____Yes____No

10. What do you do?_____

_____

11. When you are under stressful situations, do you tend to eat more? Explain:

_____

_____

12. Do you eat when you are bored? ____Yes____No

13. 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

14. How many cups of plain water do you drink in 1 day?_____

15. How many sodas do you drink in 1 day? _____

16. Regular or diet?_____

17. How many caffeinated beverages do you drink in 1 day?_____

18. How frequently do you eat out for lunch?_____

19. How frequently do you eat out for dinner?_____

20. How frequently do you eat fast food?_____

Name_____ Date of Birth_____

21. Please fill in what you eat on a **typical** day. Use household measurements and 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?

_____Resistance training _____Aerobic

_____Flexibility training _____Weight training _____None

2. Please list your specific forms of exercise:

_____

_____

_____

3. How many times do you exercise each week?

_____0 _____1-3 _____4-5 _____6-7 _____Greater than 7

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

_____15 - 30 minutes _____60 – 75 minutes

_____30 – 45 minutes _____75 – 90 minutes

_____45 – 60 minutes _____90 minutes or greater

Name_____ Date of Birth_____

WOMEN

1. Do you still have monthly periods? ____Yes____No
2. Age at onset of menstruation_____
3. First day of last menstrual period_____
4. Duration of periods_____
5. Are/were your periods regular? ____Yes____No
6. Do/did you have painful or heavy periods? ____Yes____No
7. # of pregnancies, weight gain and complications_____
8. When was your last PAP test?_____
9. When was your last mammogram?_____
10. When was your last Dexa scan (bone density measurement)?_____
11. Do you take any hormone replacement therapy (HRT)? ____Yes____No
12. Medication and dosage:_____
13. What is your method of contraception?_____
14. Are you having any symptoms of menopause or peri-menopause or have any other hormone-related health issues? List the approximate date of onset for all that apply:

Date of Onset

_____Decreased Sex Drive
_____Poor Concentration/Mental Fog
_____Forgetfulness
_____Weight Gain
_____Sleep Disturbances
_____Irritability
_____Hot Flashes
_____Infertility
_____Premenstrual syndrome (PMS)
_____Polycystic Ovarian Syndrome (PCOS)
_____Endometriosis
_____ _____
_____ _____
_____ _____