*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/ PHONE #_____

EMERGENCY CONTACT _____

RELATIONSHIP_____PHONE NUMBER_____

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 |
|---|---|
| | |
| | |
| | |
| | |

**MEDICAL 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 weight? (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/Supplements | Pounds 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_____

25. 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 _____Walking

_____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
_____ _____
_____ _____
_____ _____

Name_____ Date of Birth_____

**MEN**

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

| **Date of Onset** | |
|---|---|
| _____ | Decreased erections/erectile dysfunction |
| _____ | Decreased sex drive |
| _____ | Moodiness |
| _____ | Poor Concentration/Mental Fog |
| _____ | Weight gain |
| _____ | Increased frequency of urinating at night |
| _____ | Fatigue |
| _____ | Irritability |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

2. Have you ever been diagnosed with prostate cancer? ____Yes____No
3. What was the date of your last PSA test?_____