

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 ALLERGIESADDRESS

(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?

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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!