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**:

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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
60 – 75 MINUTES
30 – 45 MINUTES
75 – 90 MINUTES
45 – 60 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!