

Name _____

Birth Date _____

Kenton T. Bruice, M.D., P.C.

Address: _____

Telephone (best place to leave a message): _____ mobile / home / work (circle one)

Alternate telephone: _____ mobile / home / work (circle one)

Email: _____

Insurance carrier: _____

How did you hear about us: _____

How would you rate your general health? ___ Excellent ___ Good ___ Fair ___ Poor

Primary reason for today's visit: _____

Other concerns: _____

REVIEW OF SYMPTOMS:

Please rate your symptoms: 0 = none 1 = mild 2 = moderate 3 = severe

Hot flashes	0	1	2	3	Forgetfulness	0	1	2	3	Low libido	0	1	2	3
Night sweats	0	1	2	3	Difficulty concentrating	0	1	2	3	Acne	0	1	2	3
Sleep disturbances	0	1	2	3	Rapid heart rate	0	1	2	3	Hair Loss	0	1	2	3
Irritability	0	1	2	3	Motivation	0	1	2	3	Joint pain	0	1	2	3
Anxiety	0	1	2	3	Depression	0	1	2	3	Cravings	0	1	2	3
Low energy	0	1	2	3	Headaches	0	1	2	3					

How much do you weigh? _____ What is your ideal weight? _____

MEN'S HEALTH QUESTIONS:

Physical activity (how many times/wk): _____ Relationship status: ___ Married ___ Single
 Difficulty maintaining erections: ___ Yes ___ No ___ Sexually active: ___ Yes ___ No ___ Not currently
 Spontaneous erections: ___ Yes ___ No ___ Frequency: _____

HEALTH MAINTENANCE SCREENING TESTS:

Physical exam	___ Yes ___ No	Date _____	Abnormal? ___ Yes ___ No
Cholesterol test	___ Yes ___ No	Date _____	Abnormal? ___ Yes ___ No
Sigmoidoscopy or colonoscopy	___ Yes ___ No	Date _____	Abnormal? ___ Yes ___ No
Prostate exam	___ Yes ___ No	Date _____	Abnormal? ___ Yes ___ No

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?
___ Yes ___ No

Tobacco Use:

Cigarettes ___ Never or Quit Date _____ Current Smoker: packs/day # of yrs _____

MEDICATIONS: Prescription medicines only:

Medication:

Dose (e.g. mg/pill):

times per day:

Allergies or reactions to medications: _____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems (with dates).

<input type="checkbox"/> Heart disease specify type: _____	<input type="checkbox"/> Diabetes _____ Asthma/Lung disease	<input type="checkbox"/> Thyroid problem _____ Cancer specify: _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> High cholesterol		

SURGICAL HISTORY: Please list all prior operations, with dates:

FAMILY HISTORY: Please list any family members (parent, sibling, grandparent, aunt, or uncle) who experience any of the following conditions:

Heart disease: _____	High cholesterol: _____
Stroke: _____	High blood pressure: _____
Bleeding or clotting disorder: _____	Genetic disorders: _____
Cancer, specify type: _____	Diabetes: _____
Other: _____	