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): _____
Difficulty maintaining erections: ___ Yes ___ No ___
Spontaneous erections: ___ Yes ___ No ___ Frenquency: _____

Relationship status: ___ Married ___ Single
Sexually active: ___ Yes ___ No ___ Not currently

**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).

___ Heart disease
specify type: _____
___ High blood pressure
___ High cholesterol
___ Diabetes
___ Asthma/Lung disease
___ Kidney disease
___ Thyroid problem
___ Cancer
specify: _____

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