_____
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	Vaginal dryness	0	1	2	3
Night sweats	0	1	2	3	Difficulty concentrating	0	1	2	3	Low libido	0	1	2	3
Sleep disturbances	0	1	2	3	Rapid heart rate	0	1	2	3	Acne	0	1	2	3
Irritability	0	1	2	3	Breast tenderness	0	1	2	3	Hair Loss	0	1	2	3
Anxiety	0	1	2	3	Bloating	0	1	2	3	Joint pain	0	1	2	3
Depression	0	1	2	3	Headaches	0	1	2	3	Cravings	0	1	2	3
Low energy	0	1	2	3										

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

WOMEN'S HEALTH HISTORY:

Date of first day of most recent period: _____
How frequently are you having periods: _____
Age at which you stopping having periods: _____

Sexually active: ___ Yes ___ No ___ Not currently
Birth control method _____ or ___ None needed
Number of children/ages: _____

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
Women: Mammogram	___ Yes ___ No	Date _____	Abnormal? ___ Yes ___ No
Women: pap smear	___ Yes ___ No	Date _____	Abnormal? ___ Yes ___ No
Dexascan (osteporosis)	___ 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: _____