HEALTH HISTORY QUESTIONNAIRE

Your honest replies to the questions within this questionnaire will assist Dr. Ruterbusch in developing a comprehensive and appropriate treatment plan for you.
All answers and information contained in this questionnaire will be kept confidential.

Name *(Last, First, M.I.):*		M F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Age:		**Height:**	**Weight:**
Address:		**City:**	**State:** **Zip:**
Email address:		**Phone Number:** Home?	
Primary Care or referring doctor:		**Date of last physical exam:**	

Please describe your goals, area(s) of concern, and issues that you would like addressed:

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Please List ALL current or past hormone replacement or testosterone therapy medically supervised or otherwise

Name the Drug	Date Prescribed	Strength	Frequency Taken

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

	Age	Significant health problems		Age	
Father			**Children**		
Mother					
Sibling					
			Grandmother *Maternal*		
			Grandfather *Maternal*		
			Grandmother *Paternal*		
			Grandfather *Paternal*		

Is stress a major problem for you?	Yes	No
Do you feel depressed?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with eating or your appetite?	Yes	No
Do you cry frequently?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever seriously thought about hurting yourself?	Yes	No
Do you have trouble sleeping?	Yes	No
Have you ever been to a counselor?	Yes	No

Please explain any yes answers:

_____

Age at onset of menstruation:		
Date of last menstruation:		
Period every_____days		
Heavy periods, irregularity, spotting, pain, or discharge?	Yes	No

Number of pregnancies_____Number of live births _____		
Are you pregnant or breastfeeding?	Yes	No
Have you had a D&C, hysterectomy, or Cesarean?	Yes	No
Any urinary tract, bladder, or kidney infections within the last year?	Yes	No
Any blood in your urine?	Yes	No
Any problems with control of urination?	Yes	No
Any hot flashes or sweating at night?	Yes	No
Do you experience vaginal dryness/painful intercourse?	Yes	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	Yes	No
Experienced any recent breast tenderness, lumps, or nipple discharge?	Yes	No
Date of last pap and mammogram exam?		
Name/Contact information of your OB/GYN:		

Do you usually get up to urinate during the night?	Yes	No
If yes, # of times ____		
Do you feel pain or burning with urination?	Yes	No
Any blood in your urine?	Yes	No
Do you feel burning discharge from penis?	Yes	No
Has the force of your urination decreased?	Yes	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes	No
Do you have any problems emptying your bladder completely?	Yes	No
Any difficulty with erection or ejaculation?	Yes	No
Any testicle pain or swelling?	Yes	No
Date of last prostate and rectal exam?	Yes	No
Name/Contact information of Urologist (if applicable):		

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

Skin	Chest/Heart	Recent changes in:
Head/Neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort:
Lungs	Circulation	

Please explain any yes answers referenced above:

Hormone Deficiency Questionnaire

Sign and Symptom	Never	Sometimes	Often	Sign and Symptom	Never	Sometimes	Often
Low Mood/Depression				Decrease in lean muscle			
Irritability				Muscle Soreness/Weakness			
Anxiety				Body/Joint Aches			
Anger/Aggression				Decrease in strength/Stamina			
Discouragement/Pessimism				Elevated Blood Pressure			
Decreased interest in activities/relationships				Digestive Problems			
Decreased productivity at work				Low blood Sugar/hypoglycemia			
Decreased initiative/motivation/drive				Sweet/Carb Cravings			
Concentration Problems				Caffeine/Stimulant Cravings			
Memory problems					**Mild**	**Moderate**	**Severe**

Foggy Thinking				Increased fat on hips/breast/thighs			
Lower Libido				Weight Loss			
Erectile Dysfunction				Weight Gain			
Decreased Morning Erections				Body/Head Hair Loss			
Increased Fatigue				Dry Skin/ Thinning Skin			

Please indicate services you are interested in:

- ☐ Testosterone Replacement Therapy
- ☐ Bio-identical Hormone Therapy
- ☐ Growth Hormone Restoration
- ☐ Medical Weight Control
- ☐ Cosmetic/Skincare
- ☐ Nutritional Supplements
- ☐ IV infusion
- ☐ Discounted Lab work

Please sign and date below, indicating that you have answered the questions accurately and to the best of your ability.

Patients Name (Printed)_____

Patient Signature _____ Date _____