

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.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Age:	Height:	Weight:
Address:	City:	State: Zip:
Email address:	Phone Number:	Cell or Home?
Primary Care or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

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

HEALTH HABITS AND PERSONAL SAFETY

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

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

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you been diagnosed with HIV? If yes, date of diagnosis _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
			<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother Maternal		
	<input type="checkbox"/> F		Grandfather Maternal		
<input type="checkbox"/> M		Grandmother Paternal			
<input type="checkbox"/> F		Grandfather Paternal			

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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: _____

WOMEN ONLY- PLEASE EXPLAIN ANY "YES" ANSWERS BELOW

Age at onset of menstruation:	
Date of last menstruation:	
Period every _____ days	

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

MEN ONLY- PLEASE EXPLAIN ANY "YES" ANSWERS BELOW

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

OTHER PROBLEMS

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

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> 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							
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)

Patients Signature

Date