Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

Your honest replies to the questions within this questionnaire will assist Dr. Jeffrey 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:**		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

PH: 904-589-0750
FX:

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

☐ 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

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ 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?	☐ Yes	☐ No
	Have you been diagnosed with HIV? If yes, date of diagnosis_____	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

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: _____

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

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)

_____ _____
Patients Signature Date