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| Original Date:   |  |
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| Dates Revised:   |  |
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## **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.

|  | na miormadon e   |  |             |            |           |  |               |
|--|--|--|-------------|------------|-----------|--|---------------|
| Name (Last, First, M.I.):                    |  |  |             | ) M<br>) F | DOB:      |  |               |
| Marital status:                              | ☐ Single   | ☐ Partnered  | ☐ Marrie    | d D:       | Separated | ☐ Divorced   | ☐ Widowed     |
| Age:   | THE THE THEOREM SECTION AND THE SECTION SECTIO |  | Heig        | ht:        |           | The commence of the strength and department in the strength and the strength in the strength and the strengt | Weight:       |
| Address:                                     | and manifest a time to remain and single to provide and that it desired  | and it measured its attributes given a new cashed hear the proposed containing an ability design being the   | City:       |            |           | State:   | Zip:          |
| Email address:                               | na analika ito shini yake dijera kwa nakimini ngajiyora wajajia ati a Pepperijiwa i  | and the first of the control of the first of the control of the co | Phor        | ne Num     | ber:      |  | Cell or Home? |
| Primary Care or referring doctor:            |  |  | Date        | of last    | physical  | exam:  |               |
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| Please describe your goals, area(s) of conce |  |  | ld like add | iressed    |           |  |               |
|  |  |  |             |            |           |  |               |
|  |  |  |             |            |           |  |               |
| Surgeries                                    | D  |  |             | Tables and | Hospital  |  | ,             |
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| 2  |  |  |             |            |           |  |               |
|  |  |  |             |            |           |  |               |
|  |  |  |             |            |           |  |               |
| Other hospitalizations                       | _  |  |             |            | Hospital  |  |               |
| Year   | Reason   |  |             |            |           |  |               |
|  |  |  |             |            |           |  |               |

PH: 904-589-0750

FX:

|  | Date Prescribed   | Strength   |  | Frequency Taken   |   |
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|  | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim  | IN THIS QUESTIONNA<br>e)<br>b stairs, walk 3 blocks,   | AIRE ARE OPTIONAL AND WI   | ILL BE KEPT STRICTLY COI  | NFIDENTIAL.   |
|  | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous ex   | o IN THIS QUESTIONNA<br>e)<br>b stairs, walk 3 blocks,<br>sercise (i.e., work or rec   | AIRE ARE OPTIONAL AND Wi<br>golf)<br>creation, less than 4x/week fo  | ILL BE KEPT STRICTLY COI  | NFIDENTIAL.   |
|  | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous ex   | o IN THIS QUESTIONNA<br>e)<br>b stairs, walk 3 blocks,<br>sercise (i.e., work or rec   | AIRE ARE OPTIONAL AND WI   | ILL BE KEPT STRICTLY COI  |   |
| Exercise   | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous ex   | o IN THIS QUESTIONNA<br>e)<br>b stairs, walk 3 blocks,<br>sercise (i.e., work or rec   | AIRE ARE OPTIONAL AND Wi<br>golf)<br>creation, less than 4x/week fo  | ILL BE KEPT STRICTLY COI  | □ Yes □   |
| Exercise<br>Diet   | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous exercise ☐ Regular vigorous exercise   | in This Questionna<br>e)<br>b stairs, walk 3 blocks,<br>tercise (i.e., work or recreations (i.e., work or recreations)   | golf) creation, less than 4x/week for 30 minutes   | ILL BE KEPT STRICTLY COI  |   |
| Exercise   | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous exercise ☐ Regular vigorous exercise Are you dieting?  | o IN THIS QUESTIONNA<br>e)<br>b stairs, walk 3 blocks,<br>sercise (i.e., work or recreatise (i.e., work or recreatise (i.e., work or recreations)  | golf) creation, less than 4x/week for 30 minutes   | ILL BE KEPT STRICTLY CON  | □ Yes □   |
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| Exercise  Diet  Caffeine  Alcohol  | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous exerce Are you dieting?  If yes, are you on a physe # of meals you eat in an Rank salt intake Rank fat intake ☐ None # of cups/cans per day?  Do you drink alcohol?  If yes, what kind? How many drinks per ween   | in THIS QUESTIONNA  is tairs, walk 3 blocks, sercise (i.e., work or recreation prescribed medical average day?  Hi  Hi  Coffee   | golf) creation, less than 4x/week for 30 minutes all diet?  Med  Med  Tea  | ILL BE KEPT STRICTLY COI  | ☐ Yes ☐   |
| Exercise  Diet  Caffeine   | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous exerce Are you dieting?  If yes, are you on a physi # of meals you eat in an Rank salt intake Rank fat intake ☐ None # of cups/cans per day?  Do you drink alcohol?  If yes, what kind? How many drinks per weal are you concerned about   | in THIS QUESTIONNA  b)  b)  b)  b)  cercise (i.e., work or recreation prescribed medical average day?  | golf) creation, less than 4x/week for 30 minutes all diet?  Med  Med  Tea  | ILL BE KEPT STRICTLY COI  | ☐ Yes ☐ ☐ Yes ☐ ☐ Yes ☐   |
| Exercise  Diet  Caffeine  Alcohol  | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous exerce Are you dieting?  If yes, are you on a physi # of meals you eat in an Rank salt intake Rank fat intake ☐ None # of cups/cans per day?  Do you drink alcohol?  If yes, what kind?  How many drinks per we Are you concerned about Do you use tobacco?                        | in THIS QUESTIONNA  b)  b)  b)  b)  cercise (i.e., work or recreation prescribed medical average day?  | golf) creation, less than 4x/week for 30 minutes all diet?  Med  Med  Tea  | ill BE KEPT STRICTLY COlor 30 min.)  Low Low Cola   | ☐ Yes ☐ ☐ Cigars - #/day  |
| Exercise  Diet  Caffeine  Alcohol  | ☐ Sedentary (No exercise ☐ Mild exercise (i.e., clim ☐ Occasional vigorous exerce Are you dieting?  If yes, are you on a physe # of meals you eat in an Rank salt intake Rank fat intake ☐ None # of cups/cans per day?  Do you drink alcohol?  If yes, what kind? How many drinks per we Are you concerned about Do you use tobacco? ☐ Cigarettes — pks./day | in THIS QUESTIONNA  is provided by stairs, walk 3 blocks, sercise (i.e., work or recreation prescribed medical average day?  Hi  Coffee  the amount you drink  The amount you drink  | golf) creation, less than 4x/week for 30 minutes al diet?  Med Med Tea   | ill BE KEPT STRICTLY COlor 30 min.)  Low Low Cola   | ☐ Yes ☐   |

| en anterior est partir de l'action de<br>La graphique de la graphique de la sequipar de la graphique de la graphique de l'action | Are you sexually active?   |  |  |  | П     | Yes  |  | No                                       |
|--|--|--|--|--|-------|--|--|--|
| Sex  | If yes, are you trying for a pregr   |  |  |  | Yes   |  | No   |  |
|  |  | t contraceptive or barrier method used:  |  |  |       | na saya sa sa magama da la ca  |  |  |
|  | Any discomfort with intercourse  |  |  |  |       | Yes  |  | No                                       |
|  | Illness related to the Human Im  | Imunodeficiency Virus (HIV), such as AIDS<br>ness include intravenous drug use and unpi<br>vider about your risk of this illness?  | , has become a ma<br>rotected sexual int   | ajor public health<br>ercourse. Would  | В     | Yes  | П  | No                                       |
|  | Have you been diagnosed with   | en deutsche Griff der gegeneration der Griffster der der gegeneration der der Griffster gegeneration der Grif |  |  |       | Yes  | П  | No                                       |
| al de la complèmente de l'al destruction des colons de l'action de   |  | FAMILY HEALTH HISTORY  |  |  |       |  |  |  |
|  |  |  | AGE  | SIGNIFICANT H  | FALTI | I PROI   | BLEM   | IS                                       |
|  | AGE SIGNIFICANT  | HEALTH PROBLEMS  | AGL □ M  |  |       |  | and the second s | and all the second second second         |
| Father   |  | Children   | O F  |  |       |  |  |  |
|  |  |  | □ M  |  |       |  |  | □ No       |
| Mother   |  | ment for any and a finding of the seasons agreed and another the seasons are also also also also also also also also   | □М   | rinculari como e esencidado in los registifos e describado com esenção sel estado un esenção de como especia d   |       |  |  |  |
| Sibling  | □ M<br>□ F   |  | □ F  |  |       |  |  | and the second                           |
|  | □ M<br>□ F   |  |  |  |       | *** A COLOR PROPERTY OF THE PARTY OF THE PAR | and the second second  |  |
|  | □ M  | Grandmother  Maternal  |  |  |       |  | DBLEMS  No   |  |
|  | □ F  | Grandfather  |  | a Paraget a common in produces in the African and an executable properties of the desired in the contract of t |       |  |  | No N |
|  |  | Maternal   |  |  |       | No estado do finicipación  |  |  |
|  | □ M<br>□ F   | Grandmother Paternal   |  |  |       |  | □ N  | en greggen blev frauer vite 18           |
|  | M  | Grandfather Patemal  |  |  |       |  |  | No N |
| professor calculated system appropriate to all the set factors of plants are set on the  | F CONTROL OF THE PROPERTY OF T | Paterna  |  |  |       |  |  |  |
|  |  | MENTAL HEALTH  |  |  |       | a general mention of the section of  |  |  |
|  |  |  | ti di tangga mengangan kanangan sebahah kentang pengan kanangan pengangan kentangan pengangan pengangan pengan | and Associated States as the excellent and all the first an included according combination for the States of the s |       | Yes  |  | No                                       |
| Is stress a ma   | ijor problem for you?  |  |  |  | П     | Yes  |  | No                                       |
| Do you feel d  | epressed?  |  |  |  |       |  | 1  |  |
| Do you panic   | when stressed?   |  |  |  |       | Yes  | 1  |  |
| Do you have  | problems with eating or your appetite  | ?  |  |  |       |  |  |  |
| Do you cry fr  |  |  |  |  |       | Yes  |  |  |
|  | er attempted suicide?  |  |  |  |       | Yes  | è  |  |
|  | er seriously thought about hurting you   | irself?  |  |  |       | Yes  | 1  |  |
|  | trouble sleeping?  |  |  |  |       | Yes  |  |  |
| Have you ev  | er been to a counselor?  |  |  | and have been for given that the engineering temperature for an execution of a security of the six states of   |       | Yes  | بال.   | NO                                       |
| Please expl  | ain any "yes" answers:   |  |  |  |       |  |  |  |
|  |  | NLY- PLEASE EXPLAIN ANY "YES   | " ANSWERS B  | FLOW   |       |  |  |  |
|  | WOMEN O  | NLY- PLEASE EXPLAIN ANY TES  |  |  |       |  |  |  |
| Age at onset   | of menstruation:   |  |  |  |       |  |  |  |
| Date of last   | menstruation:  |  |  |  |       |  |  |  |
| Period every   | days   |  |  |  | _     | V  | _  |  |
| Heavy perio  | ds, irregularity, spotting, pain, or discr   | narge?   |  |  |       | Yes  | Ц  | ı N                                      |
|  |  |  |  |  | PH    | l: 904-  | -589-  | 0750                                     |
| Kick Some M  | ass  |  |  |  |       |  |  | 4  |

| Number of pregnanciesNumber of   | live births    |                                |                         |                       |                |                                |   |    |
|--|----------------|--------------------------------|-------------------------|-----------------------|----------------|--------------------------------|---|----|
| Are you pregnant or breastfeeding?   |                |                                |                         |                       |                | Yes                            |   | No |
| lave you had a D&C, hysterectomy, or Ce  | sarean?        |                                |                         | 8                     |                | Yes                            |   | No |
| any urinary tract, bladder, or kidney infect   |                | 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/painfu   | l intercourse? |                                |                         |                       |                | Yes                            |   | No |
| Do you have menstrual tension, pain, bloa  |                | , or other symptoms at or ar   | ound time of period?    |                       |                | Yes                            |   | No |
| Experienced any recent breast tenderness   |                |                                |                         |                       |                | Yes                            |   | No |
| Date of last pap and mammogram exam?   |                | <b>,</b>                       |                         |                       |                |                                |   |    |
| Name/Contact information of your OB/GY   |                |                                |                         |                       |                |                                |   |    |
| rame/contact information of your object  |                |                                |                         |                       |                |                                |   |    |
|  |                |                                |                         |                       |                | orania no servicio di selle di | y to per regio person selegici di altra |    |
| STATE A propriet in the Control And Mark State And Address representation for the Annual State And Annual State Annual Sta |                |                                |                         |                       | and the second |                                |   |    |
|  |                |                                |                         |                       | Tn             | Voc                            |   | No |
| Do you usually get up to urinate during th   | ne night?      |                                |                         |                       |                | Yes                            | 14/10                                   | NO |
| f yes, # of times  |                |                                |                         |                       |                | Vos                            | -                                       | No |
| Do you feel pain or burning with urination   | n?             |                                |                         |                       |                | Yes                            |   | No |
| Any blood in your urine?   |                |                                |                         |                       |                | Yes                            |   | No |
| Do you feel burning discharge from penis   | s?             |                                |                         |                       |                | Yes                            |   | No |
| Has the force of your urination decreased  |                |                                |                         |                       |                | Yes                            |   | No |
| Have you had any kidney, bladder, or pro   |                | s within the last 12 months?   |                         |                       |                | Yes                            |   | No |
| Do you have any problems emptying you  |                |                                |                         |                       |                | 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 (i   | f annlicable). |                                |                         |                       |                |                                |   |    |
| Name/Contact information of ofologist (  | і арріісавісу. |                                |                         |                       |                |                                |   |    |
|  |                |                                |                         |                       |                |                                |   |    |
|  |                |                                |                         |                       |                |                                |   |    |
| Check if you have, or have had, any sy   | mptoms in the  | following areas to a significa | nt degree and briefly e | xplain.               |                |                                |   |    |
|  |                |                                |                         |                       |                |                                |   |    |
| □ 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                    |                         |                       |                |                                |   |    |
|  |                |                                |                         |                       |                |                                |   |    |

January office, ordinger and

Hormone Deficiency Questionnaire Often Sometimes Never Often Sign and Sometimes Sign and Symptom Never **Symptom** Decrease in lean Low Mood/Depression muscle Muscle Irritability Soreness/Weakness Body/Joint Aches Anxiety Decrease in Anger/Aggression strength/Stamina Elevated Blood Discouragement/Pessimism Pressure Digestive Problems Decreased interest in activities/relationships Low blood Decreased productivity at work Sugar/hypoglycemia Sweet/Carb Decreased initiative/motivation/drive Cravings Caffeine/Stimulant Concentration Problems Cravings Severe Mild **Moderate** Memory problems Increased fat on Foggy Thinking hips/breast/thighs Weight Loss Lower Libido Weight Gain **Erectile Dysfunction** Body/Head Hair **Decreased Morning Erections** Dry Skin/ Thinning Increased Fatigue 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) Date Patients Signature