GORDON C. GUNN, M.D.
GYNECOLOGY • UROLOGY • WOMEN'S WELLNESS
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PATIENT MEDICAL HISTORY - MALE

Legal Name: _____ **Age:** _____ **Appointment Date:** _____

Marital Status: _____ **Referred by:** _____

Name(s) of your primary care and/or specialist physician(s) (e.g. Family, Cardiologist, Urologist, etc.):

_____

HISTORY OF PRESENT ILLNESS

Describe reason(s) for your visit: _____

_____

Do you experience <u>any</u> of the following cardiovascular symptoms: ☐N ☐Y If yes, please describe

Chest discomfort or pain, palpitations (unusual heart beat), rapid or irregular heart beat, unusual fatigue, leg swelling, shortness of breath, dizzy spells?

_____
_____
_____

Have you been diagnosed with <u>any</u> of the following: ☐N ☐Y If yes, please describe

Heart disease, aortic or mitral value disease, shortness of breath, hypertension (high blood pressure), carotid artery disease, peripheral artery disease, atrial fibrillation, diabetes or metabolic syndrome?

_____
_____
_____

Are you taking any medication(s) for the following conditions: ☐N ☐Y If yes, See **Medication Sheet**

Heart disease, stroke, high blood pressure, elevated cholesterol, arrhythmia (abnormal heart rhythm), diabetes?

_____
_____

Are you taking nutritional supplements? ☐N ☐Y If Yes, please list (with dose):

_____

_____

REVIEW OF CURRENT SYMPTOMS

Indicate and describe <u>any</u> of the following symptoms you are experiencing:

- **General:** headaches, sleep issues, weight change, fatigue? ☐N ☐Y _____
- **Eyes:** double vision, glaucoma, dryness? ☐N ☐Y _____
- **Ears, Nose, or Throat:** sinus, difficulty swallowing? ☐N ☐Y _____
- **Respiration:** asthma, chronic cough, bronchitis? ☐N ☐Y _____
- **Gastro-Intestinal:** chronic abdominal pain, bloating, liver disease, jaundice, reflux, diarrhea, constipation, rectal bleeding, stool leakage? ☐N ☐Y _____
- **Urinary:**
  - Recent kidney or bladder infection? ☐N ☐Y
  - Able to go for more than 3 hours without urination? ☐N ☐Y If no, how often? Every _____ Hrs.
  - Regularly get up at night to urinate? ☐N ☐Y If yes, how often? _____
  - Slow urinary stream? ☐N ☐Y
- **Endocrine:** diabetes, thyroid disease, fatigue? ☐N ☐Y _____
- **Hematologic / Lymphatic:** swollen glands, anemia? ☐N ☐Y _____
- **Musculo-Skeletal:** neck, back or joint pain? ☐N ☐Y _____
- **Neurologic:** numbness, seizures, history of stroke or TIA? ☐N ☐Y _____

PERSONAL, FAMILY, SOCIAL & HEALTH SCREENING HISTORY

Personal History:

- **Illnesses or Diseases:** (Please list)

  _____ _____

  _____ _____

- **Major Operations:** (Please List & Indicate Year of Surgery)

  _____ _____

  _____ _____

- **Family History:** Do <u>any</u> of your family members have a history of: Heart Disease; Stroke, Diabetes; Cancer; Osteoporosis? **If yes,** please <u>list</u> each disease and age if deceased.
  - Father: _____
  - Mother: _____
  - Brother(s): _____
  - Sister(s): _____
  - Aunt(s): _____
  - Grandmother(s): _____
  - Grandfather(s): _____

- **Social History:**
  - Do you smoke? ☐N ☐Y If yes, number of packs/day? _____ Number of years? _____
  - Do you drink alcohol? ☐N ☐Y If yes, more than 2 drinks/day? ☐N ☐Y If yes, amount? _____
  - Do you exercise regularly? ☐N ☐Y If yes, describe: _____
  - What is your occupation? _____
  - What are your hobbies? _____
  - What is your level of stress: ☐None ☐Low ☐Moderate ☐High

Health Screening Tests:

Have you had any of the following tests? If yes, please indicate the most recent year performed.

- Cardiovascular Testing:
  - EKG (electrocardiogram) ☐N _____ ☐Y _____ Year _____
  - Carotid Artery Ultrasound (Stroke Risk) ☐N _____ ☐Y _____ Year _____
  - Echo Cardiogram ☐N _____ ☐Y _____ Year _____
  - Stress Test ☐N _____ ☐Y _____ Year _____
  - Stress Echo Cardiogram ☐N _____ ☐Y _____ Year _____
  - Angiogram ☐N _____ ☐Y _____ Year _____
- Bone Density (DXA Scan) for Osteoporosis ☐N _____ ☐Y _____ Year _____
- Colonoscopy ☐N _____ ☐Y _____ Year _____
- Hereditary Cancer Screening:
  - Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐N ☐Y
    If yes, please describe: _____
    _____

Pharmacy Information: TO FAX YOUR PRESCRIPTION, Please Provide the Following:

Pharmacy: _____ **Address:** _____

Phone #: **Fax #:**

Doctor's Signature: _____ **Date:** _____

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www.GordonGunnMD.com

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