GORDON C GUNN, MD, FACOG
CONCIERGE PERSONALIZED CARE
GYNECOLOGY • HORMONE THERAPY
INTEGRATIVE MEDICINE

PATIENT MEDICAL HISTORY - MALE

Legal Name: _____ **DOB:** _____ **Date:** _____ **Marital Status: M S D W**

Referred by: _____

Name of Primary Care and/or Specialist Physician(s): _____

_____

HISTORY OF PRESENT ILLNESS

Describe reason(s) for your visit: _____

_____

_____

_____

Do you experience ANY of the following cardiovascular symptoms? ☐N ☐Y **If YES, Please Describe**

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

Have you been diagnosed with ANY of the following? ☐N ☐Y **If YES, Please Describe**

Coronary (heart) disease, atherosclerosis of arteries, aortic or mitral valve disease, hypertension (high blood pressure), carotid artery disease, peripheral artery disease (legs), atrial fibrillation, metabolic syndrome, diabetes mellitus, thyroid disease, prostate disease? _____

Are you taking ANY medication(s) for the following? ☐N ☐Y **If YES, Please Describe**

Heart disease, stroke, blood pressure, blood clots, thyroid, diabetes, arrhythmia (abnormal heart rhythm), elevated cholesterol _____

REVIEW OF SYMPTOMS

Are you <u>CURRENTLY</u> experiencing <u>any</u> of the following symptoms? **If YES, Please Describe:**

- **General:** headaches, sleep problems, unusual fatigue? ☐N ☐Y _____
- **Eyes:** double vision, glaucoma, dryness? ☐N ☐Y _____
- **Ears, Nose, or Throat:** sinus problems, difficulty swallowing? ☐N ☐Y _____
- **Respiration:** asthma, chronic cough, difficulty breathing? ☐N ☐Y _____
- **Breasts:** cysts, nodules, pain? ☐N ☐Y _____
- **Skin:** acne, moles, cancer? ☐N ☐Y _____
- **Gastro-Intestinal:** abdominal pain, bloating, diarrhea, constipation, IBS symptoms, liver disease, 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 frequent? Every _____ Hrs
  - Regularly get up at night to urinate? ☐N ☐Y **If Yes**, Number of times _____
  - Slow urinary stream? ☐N ☐Y
- **Endocrine:** excessive thirst, fatigue, too hot/cold? ☐N ☐Y _____
- **Hematologic/Lymphatic:** anemia, swollen glands? ☐N ☐Y _____
- **Musculo-Skeletal:** neck, back or joint pain, muscle pain? ☐N ☐Y _____
- **Neurologic:** numbness, seizures, history of stroke or TIA? ☐N ☐Y _____

PERSONAL, FAMILY AND SOCIAL HISTORY

- **Serious Illnesses, Injuries, or Hospitalizations:** (Please list}

  _____ _____

  _____ _____

- **Major Operations:** (Please list & indicate year of each surgery)

  _____ _____

  _____ _____

- **Family History:** Do **ANY** of your family members have a history of: Heart Disease; Stroke; Sudden Death; Diabetes; Cancer; Osteoporosis, Alzheimer's or Dementia? **If yes**, please **List** with age at time of diagnosis .
  - Father: _____
  - Mother: _____
  - Brother(s): _____
  - Sister(s): _____
  - Aunt(s): _____
  - Grandmother: _____
  - Grandfather: _____

- **Social History:**
  - Do you smoke? ☐N ☐Y If yes, number of packs/day? _____ How many 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 stress level? ☐ None ☐ Low ☐ Moderate ☐ High

HEALTH SCREENING STUDIES

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

			YEAR	
♦ **Cardio-Vascular Testing?**				
• EKG (Electrocardiogram)	☐N	☐Y	_____	
• Carotid Artery Ultrasound (Stroke Risk)	☐N	☐Y	_____	
• Coronary Artery Calcium Score	☐N	☐Y	_____	
• Echo Cardiogram of Heart	☐N	☐Y	_____	
• Stress Test	☐N	☐Y	_____	
• Angiogram of Heart				
♦ **Bone Density (DXA Scan) for Osteoporosis?**	☐N	☐Y	_____	
♦ **Colonoscopy**	☐N	☐Y	_____	
♦ **Immunizations:**				
• Hepatitis A/B	☐N	☐Y	_____	
• Tetanus (within last 10 years?)	☐N	☐Y	_____	
• Shingles (Age 60 or over)	☐N	☐Y	_____	
• Pneumonia (Age 65 or over)	☐N	☐Y	_____	
♦ **Hereditary Cancer Screening**	☐N	☐Y	_____	Result? _____

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PHARMACY: To FAX of E-Scribe your prescriptions, Please provide the following:

Pharmacy: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Provider's Signature: _____ Date: _____ Revised: 01.07.2018