



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 CURRENTLY experiencing any 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

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

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

Pharmacy: _____ **Address:** _____
Phone #: _____ **Fax #:** _____