Mid-Florida Age Management LLC

The office of Dr M. E. "Gene" Turner M.D.

Medical History and Symptoms Questionnaire

HIGHLIGHTED AREAS MUST BE COMPLETED

Demographics

Date Completed: ____ / _____ / _____

First Name: _____ **Middle Initial: _____** **Last Name**: _____

Address: _____

City: _____ State or Prov **Zip**: _____ **SSN: _____**

Gender: M or F

Date of Birth: ___ / ___ / _____ **Age**: ____ **Frame**: Large / Medium / Small

Height: _____ Inches **Weight:** _____ Pounds

Height at age 20: _____ Inch **Weight which you felt best:** _____ Pounds

Communication Methods

Phone (Preferred): ___ - ___ - _____

Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

Phone (Secondary): ___ - ___ - _____

Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

Phone (Tertiary): ___ - ___ - _____

Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

Phone (Fax): ___ - ___ - _____

Approved for confidential/personal information: Approved / Not Approved

E-Mail Address: _____ @ _____

Approved for confidential/personal information: Approved / Not Approved

Medical History and Symptoms Questionnaire

***Emergency Contact*:**

Name: _____ Telephone: ___ - ___ - _____

Relationship: _____

Physician Information

Dr. Turner is a consultant, not a Primary Care Physician.

☐ **No Primary Care Physician** ☐ **No Specialist**

Primary Care Physician

Name: _____

Occupation: _____

Address: _____

_____

Phone: ___ - ___ - _____

Email: _____@_____

Specialist Physician

Name: _____

Occupation: _____

Address: _____

_____

Phone: ___ - ___ - _____

Email: _____@_____

Chief Goal:

Briefly explain why it is you came to see the physician: _____

_____

Energy Level

Please rank the follow from 0 = zero energy to 10 = very energetic

What time do you awaken?	Level 1 - 10 ____	Did you eat? _____
1 hour after awaking	Level 1 - 10 ____	Did you eat? _____
10 AM (or 3 hrs after awake)	Level 1 - 10 ____	Did you eat? _____
Noon (or 5 hrs after awake)	Level 1 - 10 ____	Did you eat? _____
3-5 PM (or 7-9 hrs after awake)	Level 1 - 10 ____	Did you eat? _____
Dinner	Level 1 - 10 ____	Did you eat? _____
8 - 9 PM	Level 1 - 10 ____	Did you eat? _____
11 PM	Level 1 - 10 ____	Did you eat? _____

Medical History and Symptoms Questionnaire

Sleep Pattern

What time do you go to bed? _____
How long does it take to fall asleep? _____
How many hours do you sleep before you awaken for any reason? _____
Are you able to get back to sleep? _____
Do you awaken in the morning feeling tired? True / False
Do you snore loudly? True / False
Do you have frequent pauses in breathing while you sleep (you stop breathing for 10 seconds or longer)? True / False
Do you often wake up with a headache? True / False
Is your collar size larger than 17? True / False

Past Medical History

Have you ever had, or are you currently being treated for:

☐ Cancer

If yes, list type(s):

If yes, what year was it diagnosed?

☐ Heart disease (ex: Angiogram, Heart Attack, Congestive Heart Failure, etc)
☐ Blood Clotting Problems (blood clots in legs, hemophilia)
☐ High cholesterol or lipids (examples: Hyperlipidemia)
☐ Diabetes (diet control (borderline), Insulin dependent, hypoglycemics)
☐ High blood pressure (example: Hypertension)
☐ Arthritis or joint problems
☐ Depression
☐ Osteoporosis or Osteopenia
☐ Stomach ulcers or GERD (reflux, heartburn, indigestion)
☐ Thyroid disease
☐ Lung condition (example: asthma, emphysema, COPD)
☐ Obesity (when your body mass index was greater than 30)
☐ Other: Please list:

Medical History and Symptoms Questionnaire

Over-the-counter (OTC) issues

Please check all products that you use regularly. Check all that apply

Pain Reliever

☐ Aspirin
☐ Acetaminophen (example: Tylenol®)
☐ Ibuprofen (example: Motrin IB®)
☐ Ketoprofen (example: Orudis KT®)
☐ Naproxen (example: Aleve®)

Cough and Cold

☐ Cough + cold reliever (ex: Triaminic)
☐ Cough suppressant (ex: Robitussin DM®)
☐ Antihistamine product (ex. ChlorTrimeton)
☐ Decongestant product (ex.: Sudafed)
☐ Other (please list)

Non-Prescription Sleep Aids

☐ Non-prescription Sleep aids (example: Unisom®, Sominex®, and Nytol®)
☐ Non-prescription Diet aids/weight loss products (example: Dexatril®)

Stomach Problems

☐ Anti-diarrhea Medication (examples: Imodium®, Pepto Bismol®, and Kaopectate®)
☐ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
☐ Antacids (examples: Maalox®, Mylanta®)
☐ Acid blockers (examples: Tagamet HB®, Pepcid C®, and Zantac 75®

Prescription Medications - Hormones

Hormones previously taken. (This includes birth control, female or male hormones, thyroid)

	Hormone Name	Strength	How often per day	Year Started	Year Stopped
1					
2					
3					
4					
5					
6					
7					

Medical History and Symptoms Questionnaire

Prescription Medications – Prescribed by a Physician Page 5

This includes any medication or therapy prescribed by a physician.

	Name of Medication	Strength: units in mgs, gms, IU, mcg	At what times do you take this medication?	Year Started.	Are you currently taking this medication
1					
2					
3					
4					
5					

Nutritional/Natural Supplements:

This includes any pill, substance, or supplement that you bought at a store or pharmacy without a doctor's prescription.

	Supplement	Manufacturer	Major Ingredients	Strength of Ingredients	For what reason do you take this supplement
1					
2					
3					
4					
5					

Medical History and Symptoms Questionnaire

Allergies:

☐ No known allergies to medications

Antibiotics: ☐ Penicillin ☐ Sulfa ☐ Other antibiotic.(Please list):
Prescription Medication: ☐ Morphine ☐ Dye allergies ☐ Codeine ☐ Aspirin
Environmental Allergies: ☐ Seasonal ☐ Pet allergies ☐ Food allergies
Food Allergies: ☐ Peanuts ☐ Shellfish ☐ Soy
Any other allergy?: (please list):

Please describe the reaction to the allergen listed above, was it life-threatening:

Social History

Do you have a lot of stress in your life? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No Quit Date_____
Do you use alcohol? ☐ Yes ☐ No
Do you meditate daily? ☐ Yes ☐ No
Do you drink coffee or products containing caffeine? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
If yes, what is your occupation? _____
Is the job stressful? ☐ Yes ☐ No
Do you take breaks from working? ☐ Yes ☐ No
Is your job physically demanding? ☐ Yes ☐ No
Are you retired? ☐ Yes ☐ No
If yes, is retirement stressful? ☐ Yes ☐ No
Sexual Orientation (you may decline to answer)
☐ Heterosexual (Straight) ☐ Homosexual (Gay)
Martial Status:
☐ Single ☐ Divorced ☐ Married/Partnered
☐ Partner/Significant Others Name _____
Do you have any children? ☐ Yes ☐ No
If so, kindly list their name and their ages: _____
Do they live with you? ☐ Yes ☐ No

Medical History and Symptoms Questionnaire

Family History

Do you have a family member (mother, father, grandparents or sibling) with any of the following? You may use the abbreviations, and only these relations are of significance: M = mother, F = father, S = sister, B = brother, MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather.

☐ Breast Cancer	If so, relationship _____
☐ Prostate Cancer	If so, relationship _____
☐ Uterine Cancer	If so, relationship _____
☐ Ovarian Cancer	If so, relationship _____
☐ Colon Cancer	If so, relationship _____
☐ Fibercystic breast	If so, relationship _____
☐ Heart Disease or stroke	If so, relationship _____
☐ High Cholesterol	If so, relationship _____
☐ Diabetes	If so, relationship _____
☐ High Blood Pressure	If so, relationship _____
☐ Osteoporosis/Osteopenia	If so, relationship _____
☐ Alzheimer's Disease	If so, relationship _____

Medical History and Symptoms Questionnaire

Previous Tests

Have you had any of the following tests performed?

Mammography ☐ Yes ☐ No
If yes, list month/year:
If yes, what was the result?

PAP Smear ☐ Yes ☐ No
If yes, list month/year:
If yes, what was the result?

Uterine Ultrasound ☐ Yes ☐ No
If yes, list month/year:
If yes, what was the result?

Bone Density ☐ Yes ☐ No
If yes, list month/year:
If yes, what was the result?

Stress Test: (Treadmill) ☐ Yes ☐ No
If yes, list month/year:
If yes, what was the result?

Exercise History

Do you do exercises? ☐ Yes ☐ No
Do you do weight resistant exercises? (Lift weights) ☐ Yes ☐ No
Do you do aerobic exercises? ☐ Yes ☐ No

Type of exercise	Length of time (in minutes) exercising	Number of times per week	How many minutes on average do you sweat while exercising	How many days do you feel discomfort after this exercise

Bone Size ☐ Small ☐ Medium ☐ Large
Body Type: ☐ More Masculine (androgenic) ☐ More Feminine (estrogenic)

Medical History and Symptoms Questionnaire

Past Surgical History

Please write down all past surgical procedures and year performed:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Medical History and Symptoms Questionnaire

MEN ONLY SECTION

Prostate Questions True or False

T or F Awaken more than 2 times to urinate each night.
T or F Urinate during the day more than 5 times.
T or F Trouble with getting the stream started more than 25% of the time.
T or F Dribbling from the penis after urinating. (Drops of urine still coming out after you finished urinating.)
T or F Difficult to postpone urination, where I feel I must urinate right away.
T or F Stream (flow) of urine is not of the same force it was in earlier years.
T or F On occasion, I have had episodes of pain (burning) with urination.
T or F After urinating, feels like bladder not sufficiently emptied (feels like you still need to go more)

Sexual Health True or False

T or F Increased time needed to recover after having sex before can have sex again.
T or F Often lose erection while having intercourse
T or F Ejaculate volume is less
T or F Orgasms are less intense
T or F Desire to have sex/thoughts about sex are less frequent
T or F Feelings about wanting to have sex are diminished
T or F Spontaneous erections occur less than 5 times per month
T or F More time is needed to get an erection
T or F Hardness/firmness of your erection is less
T or F Cannot maintain an erection throughout intercourse.

Physical Health True or False

T or F Muscle mass is less
T or F Tone of your muscles is less
T or F Physical strength is diminished
T or F Fatigue in the late afternoon/early evening
T or F Have been told you have weak bones (osteopenia or osteoporosis).

Medical History and Symptoms Questionnaire

WOMEN ONLY SECTION

Gynecology History (Women only)

At what age did you first have your period (menarche)? Age:

Have you ever had Premenstrual Syndrome (PMS)? ☐ Yes ☐ No

Ever take any pain medication because of PMS? ☐ Yes ☐ No

Did you ever miss school/an event due to PMS? ☐ Yes ☐ No

Did you ever go to the hospital due to the PMS? ☐ Yes ☐ No

Are you currently suffering from PMS? ☐ Yes ☐ No

Have you ever used oral contraceptives? ☐ Yes ☐ No

If so, how many years total?

Are you currently on birth control pills? ☐ Yes ☐ No

Which BCP was the most recent one?

Did you have any side effects from taking the pill? ☐ Yes ☐ No

If yes, describe any problem(s):

Are you currently still menstruating? ☐ Yes ☐ No

What date did your last period begin? Month/Day/Year

What date did the period before the last period begin? M/D/Y

Are your periods regular? ☐ Yes ☐ No

Do you spot or bleed between periods? ☐ Yes ☐ No

Pregnancy:

How many pregnancies have you been pregnant?

How many children did you deliver?

How many children are still living?

How many miscarriages?

Did you have a tubal ligation? ☐ Yes ☐ No

If Yes, what year?

Have you had a hysterectomy (uterus removed)? ☐ Yes ☐ No

If Yes, what year?

Have your ovaries (ovary) been removed? ☐ Yes, both ☐ Yes, only one ☐ No

If Yes, what year?

Did you ever have, or currently have:

☐ Uterine fibroids ☐ Endometriosis ☐ Ovarian Cysts ☐ Fibrocystic Breasts

Medical History and Symptoms Questionnaire

SYMPTOMATIC QUESTIONNAIRE

PART 1: Both Men and Women complete this section
Please check all of the symptoms you are currently experiencing.

Estrogen dominant
- ☐ Water retention (swollen ankles and hands)
- ☐ Breasts are swollen, overdeveloped, or tender
- ☐ You think you have low thyroid
- ☐ You store your fat in the front of your stomach, your hips and your thighs
- ☐ Palpitations
- ☐ Anxiety

Progesterone Deficient
- ☐ Snoring (and you did not before)
- ☐ Urinary leakage (urine does not stop or comes out at inappropriate times)
- ☐ Aches in joints
- ☐ Varicose veins
- ☐ Weird dreams
- ☐ Lower back pain

Androgen Deficiency
- ☐ Good energy when you wake up, and all through the day until just around 6 or 7pm when you are ready to take a nap
- ☐ Trouble remembering directions
- ☐ Trouble remembering number
- ☐ Difficult hold back tears/emotions
- ☐ Decreased libido
- ☐ Muscle weakness
- ☐ Diminished feeling of well being

Medical History and Symptoms Questionnaire

Adrenal Fatigue **Page 13**

- ☐ Fatigue, especially around 2 to 4pm
- ☐ Allergies are worse
- ☐ Craving for salt and sugar
- ☐ Chemical or other sensitivities that you never had before
- ☐ You wake up after 3 hours of being asleep then you are unable to go to sleep for a few hours, until the last portion of the night between before you wake up.
- ☐ After a stressful day, you feel worn out
- ☐ When you miss a meal, you get irritable or weak
- ☐ Difficult keeping your focus and concentration
- ☐ When you get a cold, it seems to last a long time
- ☐ In the past you were an "adrenaline junkie" (liked daring thrills) but now you avoid those situations.
- ☐ Age spots appearing on arms and face

Adrenal Stress

- ☐ At night, you lie awake unable to fall asleep, but your body is tired
- ☐ You are stressed, but you are able to handle it.
- ☐ You are an "adrenaline junkie", you like daring thrills
- ☐ Hair loss all over your head.
- ☐ Weight gain, especially in front of stomach, love handles and face
- ☐ Anxiety
- ☐ Craving for sweets
- ☐ You currently work best under pressure
- ☐ After something eventful happens, you feel energized

Thyroid Deficiency

- ☐ Fatigue constant through the day
- ☐ Low stamina
- ☐ Cold hands and feet
- ☐ Intolerance to cold (you do not like winter because of the coldness)
- ☐ Weight gain
- ☐ Hair loss all over your head
- ☐ Swollen, puffy eyes
- ☐ Brittle nails

Medical History and Symptoms Questionnaire

Thyroid Excess

- ☐ Nervousness
- ☐ Irritable or angry
- ☐ Hand tremors
- ☐ Insomnia
- ☐ Palpitations (skipped heartbeats)
- ☐ Weight loss even though you are not dieting
- ☐ Diarrhea
- ☐ Warm hands and feet

GH Deficiency

- ☐ General muscle loss
- ☐ "Pot belly"
- ☐ More facial wrinkles
- ☐ Reduced exercise capacity
- ☐ Loss of concentration
- ☐ Loss of self confidence/self esteem
- ☐ Decreased in quality of sleep
- ☐ Sagging cheeks
- ☐ Thinning lips

PART 2: Women Only

Estrogen Loss

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Dry skin, eyes, or mouth
- ☐ Breast have become smaller, droopy
- ☐ Foggy thinking
- ☐ Forget names of people or objects
- ☐ Painful intercourse
- ☐ Hair loss on the crown of head

Medical History and Symptoms Questionnaire

Androgen Excess **Page 15**

- ☐ Acne
- ☐ Hair loss in the front
- ☐ Hair on face and nipple area
- ☐ Deepening of voice
- ☐ Clitoral enlargement
- ☐ Irritability/moodiness
- ☐ Insomnia

Progesterone Deficiency

- ☐ Your periods are Irregular or have stopped
- ☐ Headaches before or during your periods

Women on hormone therapy (natural or synthetic)

- ☐ Progesterone Excess
- ☐ Feeling sedated
- ☐ Heartburn
- ☐ Gastrointestinal bloating
- ☐ Depression with loss of interest
- ☐ Frequent yeast Infections

Medical History and Symptoms Questionnaire

PART 3: Men Only

Androgen Deficiency

- ☐ Low sex drive
- ☐ Energy runs out after dinner
- ☐ Decreased strength or endurance
- ☐ Have you gotten shorter?
- ☐ Decreased joy about life
- ☐ Sad, grumpy, or depressed
- ☐ Erections less strong
- ☐ Decrease in performance at work
- ☐ Decrease in performance at gym or in sports

Estrogen Excess

- ☐ Breast Development
- ☐ Nipples tender, sore, or more sensitive
- ☐ Change in your behavior to more caring and compassionate
- ☐ Difficulty with urination

Men on Testosterone Therapy

Androgen Excess

- ☐ Acne
- ☐ Hair loss on the head
- ☐ Hair growth in unwanted areas
- ☐ Deepening of voice
- ☐ Irritability
- ☐ More aggressive
- ☐ Insomnia

An appointment will not be scheduled until a completed history form has been received by the office. Send by mail, or fax to 352-861-1592. If you have any questions regarding this form, please call our office at 352-629-3311.