

A FEE OF \$25.00 WILL BE CHARGED IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT AND DO NOT CONTACT OUR OFFICE PRIOR TO 3 HOURS BEFORE YOUR APPOINTMENT

DR. BRYCE KELPIN - MEDICAL HISTORY SUMMARY QUESTIONNAIRE - MALES

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE PRIOR TO COMING IN FOR YOUR COMPLETE PHYSICAL EXAMINATION. THIS WILL ASSIST IN FORMULATING A COMPLETE SUMMARY OF YOUR CURRENT AND PAST MEDICAL HISTORY. THIS INFORMATION WILL HELP US TO MAKE THE BEST MEDICAL DECISIONS POSSIBLE IN DETERMING YOUR HEALTH CARE NEEDS. PLEASE MAKE SURE TO COMPLETE ALL 3 PAGES OF THE QUESTIONNAIRE. THANK YOU.

WHAT IS YOUR CURRENT OCCUPATION? _____

WHAT IS YOUR CURRENT MARITAL STATUS? SINGLE MARRIED OTHER _____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____

PLEASE LIST THE NAME, SEX AND AGE OF ALL YOUR CHILDREN:

<u>NAME</u>	<u>SEX (M/F)</u>	<u>AGE</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

PLEASE LIST ALL YOUR CURRENT MEDICATIONS AND DOSAGES, INCLUDING BOTH PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS:

1. _____	2. _____
3. _____	4. _____
5. _____	6. _____
7. _____	8. _____
9. _____	10. _____

DO YOU SMOKE? YES / NO HOW MUCH? _____

HAVE YOU SMOKED IN THE PAST? YES / NO HOW MUCH? _____

FOR HOW LONG? _____

WHEN DID YOU QUIT? _____

DO YOU DRINK ALCOHOL? YES / NO HOW MUCH? _____

IS YOUR ALCOHOL USE EXCESSIVE? YES / NO HAVE YOU SUFFERED FROM ALCOHOLISM?
YES / NO

HOW MANY CUPS OF COFFEE DO YOU DRINK DAILY? 0 1 2 3 4 5 6 7 8 9 10 MORE

HOW MANY CUPS OF TEA DO YOU DRINK DAILY? 0 1 2 3 4 5 6 7 8 9 10 MORE

DO YOU EXERCISE REGULARLY? YES / NO HOW MANY TIMES PER WEEK?
0 1 2 3 4 5 6 7

WHAT TYPE OF EXERCISE DO YOU DO? WALK / RUN / SWIM / BICYCLE
OTHER _____

HOW MANY YEARS AGO WAS YOUR LAST TETANUS SHOT? NEVER 1 2 3 4 5 6 7 8 9 10 MORE

HOW OFTEN DO YOU HAVE TO GET UP TO URINATE AT NIGHT? 0 1 2 3 4 5 6 7 8 MORE

TO THE BEST OF YOUR RECOLLECTION, PLEASE LIST ANY SURGERIES AND THE DATES ON WHICH THEY OCCURED:

<u>SURGERY</u>	<u>DATE</u>	<u>SURGERY</u>	<u>DATE</u>
1. _____		6. _____	
2. _____		7. _____	
3. _____		8. _____	
4. _____		9. _____	
5. _____		10. _____	

TO THE BEST OF YOUR RECOLLECTION, PLEASE LIST ANY OTHER SIGNIFICANT NON-SURGICAL HEALTH PROBLEMS WHICH YOU HAVE HAD AND THE DATES ON WHICH THEY OCCURED:

<u>MEDICAL CONDITION</u>	<u>DATE</u>	<u>MEDICAL CONDITION</u>	<u>DATE</u>
1. _____		6. _____	
2. _____		7. _____	
3. _____		8. _____	
4. _____		9. _____	
5. _____		10. _____	

PLEASE LIST ANY SIGNIFICANT FAMILY HEALTH PROBLEMS:

	<u>AGE IF ALIVE</u>	<u>AGE AT DEATH</u>	<u>SIGNIFICANT MEDICAL PROBLEM</u>
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
BROTHER	1 _____	_____	_____
	2 _____	_____	_____
	3 _____	_____	_____
SISTER	1 _____	_____	_____
	2 _____	_____	_____
	3 _____	_____	_____
OTHER	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

SPECIFICALLY, IS THERE ANY HISTORY OF HEART DISEASE, STROKE, PROSTATE OR BOWEL CANCER (PLEASE NOTE ABOVE)

DO YOU HAVE ANY OTHER HEALTH CONCERNS AT THIS TIME?

1. _____

3. _____

2. _____

4. _____