SINAN DUZYUREK, MD, PLLC

PATIENT INTAKE FORM- CLINICAL INFO SECTION

Your Name:________________________________ Today's Date:___________

Reasons for Seeking Professional Evaluation and/or Treatment

During your session today Dr. Duzyurek will be conducting a diagnostic interview and exam with you in order to identify symptoms, syndromes, or other issues that may benefit from the professional services he provides, as well as those issues that may require a referral. In order to help make this process more productive, please *briefly* state below in your own words the main reasons for making this initial appointment. In other words, in a nut shell (in a paragraph or two), describe *the main current issues, symptoms, questions or areas of concern* that have prompted this appointment. You may indicate the higher priority issues with an asterix. Also, if applicable, indicate the reason for seeing Dr. Duzyurek *now,* as opposed to an earlier point in the past; in other words, *why now?*

ARE YOU ALLERGIC TO ANY DRUG(S) or OTHER THINGS? Yes☐ No☐; if YES, to what?

WHAT IS YOUR HEIGHT?:_______________ **YOUR WEIGHT:**_____________ ☐ Do Not Know

Do You Need More Space for this section? Yes ☐ No☐ If Yes, please use the back of this sheet.

Current Treatment: Are you *currently* on any medications or in some form of therapy with someone? If so, please indicate below the names and dosages of current medications, and for how long you've been on them. Also, if applicable, state the name and contact info of the doctor or therapist, and for how long and with what frequency you have been seeing him/her. You may also include other things you have tried on your own to help with your problem, and how they worked for you.

PAST MEDICATIONS

Please list in the space below all prescription medications you took or tried in the past, if any, and the reason they were discontinued:

Have you had any diagnostic tests (blood tests, etc.) done in the last 12 mo? Yes☐ No☐

If, Yes what did those tests entail (if known):____

HOW LONG AGO WAS YOUR LAST EJACULATION VIA ANY MEANS (SUCH AS INTERCOURSE, ORAL SEX, HANDJOB, OR MASTURBATION)?________________ HOURS/DAYS/WEEKS/MONTHS AGO

RATE THE QUALITY OF YOUR MOST RECENT ERECTION (HARDON): ☐Very Firm and well-sustained ☐ Quite firm and well-sustained ☐ Hard enough for penetration but not adequately rigid ☐ Good hardness first, but then lost ☐ Barely enough hardening to do anything with it ☐ Enlarged but Not hard enough to do anything enjoyable with it ☐ Not even enlarged ☐ Other____

Do You Need More Space for this section? Yes ☐ No☐ If Yes, please use the back of this sheet.

PERSONAL MEDICAL HISTORY

Please Check the Corresponding Box Below to Indicate Any Physical Health Conditions You Have Had:

☐ *History of Seizures/Convulsions/Fits/Epilepsy*
☐ History of Stroke
☐ Diabetes
☐ Heart Disease
☐ Kidney Disease
☐ Hypothyroidism
☐ Sex Hormone Problem
☐ HIV Infection
☐ Deafness or Hearing Loss
☐ Vision Problem (not corrected by lenses or Lasik)
☐ Irritable Bowel Syndrome
☐ Tuberculosis
☐ Sexually Transmitted Disease
☐ Gynecological Condition
☐ Asthma
☐ High Cholesterol or Other Blood Lipid Disorder
☐ Lupus
☐ Multiple Sclerosis
☐ Migraine
☐ Fibromyalgia
☐ Anemia
☐ Arthritis
☐ Overweight or Obesity
☐ Loss of Appetite for Sex
☐ Erectile Disorder
☐ *Any Unremovable Metalic Object in Your Head*
☐ A Prostate Problem
☐ *History of Head Trauma*
☐ *History of Brain Surgery*
☐ High Blood Pressure
☐ Liver Disease
☐ Skin Disease
☐ Hyperthyroidism
☐ Other Hormonal (Endocrine) Disorder
☐ AIDS
☐ Glaucoma
☐ Stomach/Duodenal Ulcers
☐ Other Gastrointestinal Disorder
☐ Lyme's Disease
☐ Other Infectious Illness
☐ Acid Reflux Disease
☐ Other Lung Disease
☐ Gout
☐ Other Systemic Autoimmune Disorder
☐ Parkinson's Disease
☐ Other Headache Condition
☐ Other Chronic Pain Condition
☐ Other Blood Disorder
☐ Other Rheumatologic Condition
☐ Underweight
☐ Difficulty with Orgasm
☐ Other Sexual Dysfunction
☐ *Any Implanted Object or Device in Your Body*
☐ Other Male Sex Organ (Penis / Testis) Issue
☐ Other Condition(s):____
☐ No specific medical problem (except minor ones like common cold) to report in the past or currently

IMPORTANT: At this point, please go over the list above and indicate the condition(s) that have been professionally diagnosed with a "D" and those that are only your self-report with an "S". Also indicate those that are currently active requiring ongoing monitoring or management with an asterix (*)

Please provide pertinent specifics on your physical health history (do not include medications here):

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Do You Need More Space for this section? Yes ☐ No☐ If Yes, please use the back of this sheet.

SINAN DUZYUREK, MD, PLLC

REVIEW OF SYSTEMS

Name: ___________________________________ **Today's Date:** _________________________

The following is a screening of any CURRENT symptoms you may be experiencing today and within the last 7 days in various body systems. This screening is necessary for an integrated evaluation of your health status and its documentation is required for this visit to be eligible for insurance coverage. In each area, if you are not having any difficulties, please check "No Problems." If you are currently experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY,** or explain any that may not be listed. If you have any questions about this, please ask one of the staff members, or your doctor.

Constitutional (Health in General) ▢ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ____

Ears, Nose, Mouth & Throat ▢ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ____

C-V (Heart & Blood Vessels) ▢ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ____

Resp. (Lungs & Breathing) ▢ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ____

GI (Stomach & Intestines) ▢ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ____

Genitourinary ▢ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, erection/ejaculation problems, lump or pain in testes, sore or discharge in the genital area, painful or abnormal menstruation, painful intercourse Other: ____

MS (Muscles, Bones, Joints) ▢ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ____

Integ. (Skin, Hair & Breast) ▢ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ____

Neurologic (Brain & Nerves) ▢ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, vertigo, tremor, loss of consciousness, seizures, uncontrolled motions, episodes of visual loss. Other: ____

Psychiatric (Mood & Thinking) ▢ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, suicidality, mood swings, paranoia, hallucinations, compulsions. Other: ______________________

Endocrinologic (Glands) ▢ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ____

Hematologic (Blood/Lymph) ▢ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ____

Allergic/Immunologic ▢ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, immune deficiency Other: ____

Over the Counter Drugs, Supplements, or Devices: Please list below any non-prescription drugs you are taking for treatment or prevention purposes. Include the name of the drug, strength, and the frequency (for example, once a day, twice a day, once at bed time, as needed…). Also include any over-the-counter devices, supplements, herbals, vitamins, etc.

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ALCOHOL or SUBSTANCE ABUSE or ADDICTION

Recently (Within Last 3 Months), Have You Used Alcohol to Excess or in a Problem-Causing Way? Yes☐ No☐

Recently (Within Last 3 Months), Have You Used Any Other Substance That Can Be Abused to Get High (or to escape from difficult feelings)? Yes☐ No☐

In the Past, Have you had a Period with Problem or Excessive Drinking or Alcohol Dependence? Yes☐ No☐

In the Past, Have You Had a Period with any other Substance Abuse or Addiction? Yes☐ No☐

Past Emotional History: IN ADDITION TO THE CURRENT PROBLEMS OR ISSUES THAT PROMPTED THIS APPOINTMENT, HAVE YOU ALSO EXPERIENCED ANY PSYCHIATRIC (EMOTIONAL, PSYCHOLOGICAL) SYMPTOMS, DIFFICULTIES OR PROBLEMS *IN THE PAST (Including Childhood)* ?

PLEASE CHECK THE CORRESPONDING BOX IF YOU HAD ANY ONE OF THE FOLLOWING *IN THE PAST*?

Mild Depression ☐ Moderate/Severe Depression ☐ Mild Mania (or Hypomania) ☐ Moderate/Severe Mania ☐

Panic Attacks ☐ Social Anxiety ☐ Over-Worrying/Generalized Anxiety ☐ Obsessive Compulsive Disorder ☐

Post-Traumatic Anxiety Disorder ☐ Other Anxiety issues ☐ A Sleep Disorder ☐ Irritability/Anger Issues ☐

Attention Deficit/Hyperactivity Disorder ☐ Paranoia ☐ Hallucinations ☐ Delusions ☐ Suicide Attempt ☐

Serious Thoughts of Suicide ☐ Deliberate Self-Harm (such as self-cutting) ☐ Psychosomatic Issues ☐

Problems Related to Excessive Alcohol Use (Problem Drinking) ☐ Other Substance Abuse or Dependence ☐

Relationship Difficulties ☐ An Eating Disorder ☐ Sexual Function Difficulty ☐

Other ☐ (please specifiy:____)

Do You Need More Space for this section? Yes ☐ No☐ If Yes, please use the back of this sheet.

INTIMATE RELATIONSHIP HISTORY

On a timeline, please *briefly* summarize your history of romantic and/or sexual relationships or pursuits, such as experimenting, dating experiences, short- and long-term relationships, marriages, divorces. You may also *briefly* mention any outstanding events, accomplishments, challenges, setbacks, and difficulties.

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HISTORY OF BEING SUBJECTED TO ANY KIND OF ABUSE

At any point in your life, have you suffered any physical, emotional or sexual abuse? Yes☐ No☐

If No, skip this section. If Yes, provide a *brief* summary of the specifics (including, in what way, at what age or during what period of time, by whom, and whether you received any professional help, etc)

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Do You Need More Space for this section? Yes ☐ No☐ If Yes, please use the back of this sheet.

FAMILY HISTORY OF MEDICAL or PSYCHIATRIC CONDITIONS

Among your **biological relatives** have there been any individuals with current or past known or suspected medical illnesses or psychiatric difficulties, for example, depression, bipolar disorder, an anxiety disorder, OCD, ADHD, alcohol or substance abuse or addiction, suicide, epilepsy, cancer, diabetes, heart disease, hypertension, sexual dysfunction, etc? Diagnosed and treated professionally? Have they been on any medications? If so, the name of the medication(s), if you can. Please start with first-degree relatives (parents, siblings and children), then grandparents, and then other blood relatives such as cousins, aunts, uncles, nieces / nephews, etc.

Is There Any Other Relevant Information Regarding Your Past or Family History That You Would Like to Include?

Yes☐ No☐ If Yes, please summarize here:

Do You Need More Space for this section? Yes ☐ No☐ If Yes, please use the back of this sheet.