

Endocrinology Medical History

Date: _____

Name _____ DOB _____ Marital Status _____

Preferred Pharmacy and Phone Number _____

Primary Care Physician _____ Referring Physician _____

Your History (past and present)

High Blood Pressure	Y N	Thyroid Disease	Y N	Osteoporosis	Y N
Heart Disease	Y N	Diabetes	Y N	Cancer	Y N
High Cholesterol	Y N	Prostate Disorder	Y N	Stroke	Y N
Asthma/Emphysema	Y N	Rheumatic Fever	Y N	Stomach Ulcers	Y N
Seizure Disorder	Y N	Anemia	Y N	Depression	Y N
Hepatitis	Y N	Diabetic Retinopathy	Y N		

Do you have any other medical problems not mentioned above? _____

Have you ever been hospitalized for medical reasons or surgery? (If yes, give dates and nature of illness)

Are you currently seeing any other doctors? (Please list each physician's name and condition being treated)

Do you take aspirin daily? Y N If yes, what strength _____ mg

List all medications (including birth control, vitamins and over-the-counter) *or* bring them with you.

Allergies Are you allergic to any medications Y N If yes, please list the medication and your reaction

Your Social History

Do you use tobacco? Y N Packs per day _____ How long? _____ Have you quit? _____

Do you drink alcohol? Y N How much? _____ How often? _____ Have you quit? _____

Do you use illegal drugs? Y N Type of drug _____

Have you ever abused prescription drugs? Y N

Are you under any unusual stress? Y N Explain _____

Are you sexually active? Y N Method of contraception _____

Do you exercise regularly? Y N

Name _____ DOB _____ Date _____

Family History List any relatives who have or had any conditions below

High Blood Pressure _____

Diabetes _____

Heart Disease _____

Stroke _____

High Cholesterol _____

Osteoporosis _____

Obesity _____

Cancer (and type) _____

Thyroid Disease or Thyroid Cancer _____

Other _____

If parents or siblings are deceased, please give age and cause of death _____

Review of Systems Mark any symptoms you are having

- Appetite changes; wt loss/gain _____ lbs; fever; feeling tired
- Eye pain; irritation; redness; dryness; vision changes; double vision
- Hearing problems; ringing in the ears; nasal congestion; sinus problems
- Dental problems; mouth/throat pain/sores; hoarseness; difficulty swallowing
- Chest pain; heart palpitations; fainting; lower leg swelling; blood clotting problem
- Shortness of breath; wheezing; cough,
- Abdominal pain; bloating; nausea; vomiting; constipation; diarrhea
- Painful urination; frequent urination; feeling urgency; incontinence
- MALES**-erectile dysfunction; decreased sex drive; no sex drive; enlarged breast glands; prostate problems
- FEMALES**-infertility; abnormal /heavy/light menstrual cycles; absent menstrual cycle
- Joint/muscle pain; joint swelling; muscle cramps; bone pain/fractures
- Excessive sweating; dry skin; itching; rash; hives; hair loss;
- Sudden reddening of the face, neck, chest; skin discoloration
- Excessive hair growth on face, chest, abdomen; skin discoloration
- Breast tenderness; nipple discharge; breast lumps; breast skin changes
- Tremors; dizziness; headaches; balance problems; weakness, tingling
- Sensation; feelings of numbness; memory problems; sleep problems
- Anxiety; nervousness; depression; stress
- Frequent urination; increased thirst; wakeful at night to urinate; hot flashes;
- Heat/cold intolerance
- Bleed easily; bruise easily; enlarged lymph nodes
- Hives; seasonal allergies; frequent illnesses/infections

Women Only

Last menstrual cycle _____

Number of children _____

Miscarriages? _____ Abortions? _____

Name of gynecologist _____

Have you had a bone density test? **Y N**

Date _____ Place performed _____

Date of last lab work _____

Place labs drawn _____

Last eye exam _____

Name of eye doctor _____

Men Only

Have you had a bone density test? **Y N**

Date _____ Place performed _____

Date of last lab work _____

Place labs drawn _____

Last eye exam _____

Name of eye doctor _____