Howard County Endocrinology LLC
Patient History Form

Patient Name: _____ Date of Birth: _____

Reason for today's visit: _____

Referring doctor/ physician: _____

Medical History: (Please check all that apply)

- Hypertension (high blood pressure)
- Hyperlipidemia (high cholesterol)
- Diabetes
- Diabetic Complications (eyes, kidney, feet)
- CAD (Coronary artery disease)
- Stroke
- Peripheral Vascular Disease
- Irregular Heart Beat
- Kidney Failure
- Kidney Stones
- Hypercalcemia (high calcium)
- Osteoporosis
- Fractures
- Cancer
- Liver Disease
- Anemia
- Sleep Apnea
- Thyroid Disease
- Adrenal Disease
- Testosterone (low or high)
- COPD/ Asthma
- Depression/ Anxiety/ other mental illness _____
- Other _____

Please list allergies to medications below: (If you have no allergies please write none)

Name of Medication	Reaction

Please list medications below: (If your list exceeds the space provided please bring in a list or continue to back of form)

Name of Medication	Dosage	Frequency

Name: _____
DOB: _____

Please list surgical history below:

Procedure	Date or age at time of procedure

Social History:

Do you use tobacco in any form? Yes or No
If yes, how much, which form, and how often? _____

Do you drink alcohol beverages? Yes or No
If yes, how much/ often? _____

Have you ever used recreational drugs? Yes or No
If yes, which drug and how often? _____

What is your occupation? _____

Immediate Family History:

Issue	Affected Family Member

Briefly, tell us about current symptoms/condition that brought you here:

_____
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_____
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_____
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Patient Signature: _____Date: _____