The Endocrinology Group Health History Form

Patient Name: _____ **Age**: _____

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer them. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

Allergies

List anything that you may be allergic to (medications, food, bee stings, etc) and how each affects you

Allergy	Reaction
1.	
2.	
3.	

Preferred Pharmacy

Local:

Mail Order:

Medications

Please list all the medications you are taking, including prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

Drug Name	Strength	Frequency Taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Immunization History

Immunization and most recent date. If known, otherwise skip.

Flu shot Date: _____
Hepatitis B Date: _____
Pneumonia Date: _____
Covid Vaccine Date(s): _____ _____ _____

Past Medical History

Please circle all that apply

Anemia	Eye Disease	Lung Disease
Anxiety Disorder	Heart Attack	Osteoporosis
Arthritis	HIV or AIDS	Reflux/Ulcers
Asthma	High Cholesterol	Stroke
Bleeding Disorder	High Blood Pressure	Vitamin D Deficiency
Blood Clots (or DVT)	Heart Murmur	Other:
Cancer (type)	Hyperthyroidism	
_____	Hypothyroidism	
Coronary Artery Disease	Kidney Disease	
Depression	Kidney Stones	
Diabetes (Insulin)	Leg/Foot Ulcers	
Diabetes (Non-insulin)	Liver Disease	

Past Surgical History

Surgery	Reason	Year
1.		
2.		
3.		
4.		

Obstetric and Gynecological History

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____
Births: _____
Miscarriages: _____
Abortions: _____
Cesarean sections: _____ if yes, then number: _____

Family Health History

Relation	Significant Health Problems		
Father	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Mother	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Brother/Sister	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Brother/Sister	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Grandmother (maternal)	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Grandfather (maternal)	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Grandmother (paternal)	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other
Grandfather (paternal)	Diabetes Depression Heart Disease Cancer & type	Thyroid Disease Hypertension Hyperlipidemia	Osteoporosis Stroke Other

Your Physicians

Primary Physician: _____

Referring Physician: _____

Physician(s) seen on a regular basis: _____

Other (Specify type): _____

Social History

Please circle all that apply

Education

Less than 8th grade | 2 year college | Post Graduate

High school | 4 year college | Other

Are You Working?

Yes | Looking for Work | Retired

No | Disabled

Occupation: _____

Sexually active? Yes No ***Protected Sex?*** Always Usually No

Marital Status

Married | Domestic Partner | Single

Divorced | Separated | Widowed

Do you have children? Yes No **How many?**_____ **Ages?**_____

Exercise

None

Occasional

Moderate

High Level

Frequency? <3 times a week or >3 times a week

How many minutes, on average day, do you engage in exercise?

What activity? _____

How often do you drink caffeine?

None | Moderate

Occasional | Heavy

If so? _____number of cups/cans per day

How often do you have a drink containing alcohol?

Never | 2-4 times a month | 4 or more times a week

Monthly or less | 2-3 times a week

How many standard drinks containing alcohol do you have when you drink?

1 or 2 | 3 or 4 | 5 or 6 | 7 or 9 | 10 or more

How often do you have 6 or more drinks on one occasion?

Never | Less than monthly | Monthly | Weekly | Daily or Almost daily

Drugs

Do you currently use recreational or street drugs? Yes No if yes, please list:

Tobacco

Do you use tobacco? Yes No

If not currently, did you ever use? Yes No

Cigarettes _____pkg/day Cigars _____/day Chew _____/day

How many years of tobacco use? (if applicable) _____

Patient Name: Date of Birth:

Review of Systems

Please check all that apply

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain(__lbs)
- ☐ Weight loss(__lbs)
- ☐ Decreased appetite

Eyes
- ☐ Dry eyes
- ☐ Irritation
- ☐ Vision changes
- ☐ Blurred vision

Date of last eye exam:

_____

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing
- ☐ Voice changes
- ☐ Neck swelling
- ☐ Swallowing problems
- ☐ Nose/Sinus problems

Cardiovascular
- ☐ Chest pain on exertion
- ☐ Chest heaviness
- ☐ Pressure on exertion
- ☐ Irregular heartbeats
- ☐ Palpitations
- ☐ Swelling(edema)

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Sleep apnea

Gastrointestinal
- ☐ Abdominal pain
- ☐ Changes in bowels
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Heartburn / GERD
- ☐ Vomiting

Genitourinary
- ☐ Urinary difficulties
- ☐ Nighttime Urination

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscleaches
- ☐ Muscle weakness
- ☐ History of fractures

Skin
- ☐ Dry skin
- ☐ Eczema
- ☐ Itching
- ☐ Rash
- ☐ Easy bruising

Hematologic/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Swollen glands

Allergic/Immunologic
- ☐ Hives
- ☐ Itching

Female-based
- ☐ Change in periods
- ☐ Low sex drive
- ☐ Breast tenderness
- ☐ Breast fluid leakage

Male-based
- ☐ Problems with erections
- ☐ Low sex drive
- ☐ Breast tenderness
- ☐ Breast fluid leakage
- ☐ Pain/lump in testicle

Neurological
- ☐ Dizziness
- ☐ Numbness
- ☐ Headaches
- ☐ Seizures
- ☐ Tingling sensations

Psychiatric
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Problems sleeping

Endocrine
- ☐ Problems with heat
- ☐ Problems with cold
- ☐ Excessive thirst
- ☐ Frequent Urination
- ☐ Changes in hair

Please add any other information about your health that you would like your provider to know: