LOUDOUN ENDOCRINOLOGY ASSOCIATES

Melissa J. Antonik, MD

Silpa P.K. Joshi, MD

19500 Sandridge Way Suite 180 Leesburg, VA 20176 Phone: 703-673-0171 Fax: 703-673-0178

NEW PATIENT HEALTH HISTORY FORM

1. General Information:

Name:_____Date of Birth:_____
Referring Physician/Primary Care Provider_____
Pharmacy name & address:_____Phone #:_____
Street Address:_____
City:_____State:_____ZIPCODE: _____
Cell Phone:_____ Home Phone:_____Work Phone_____

Patient's Reason for Office Visit:_____
_____
_____

2. **Patient Medical History:**
Please list any serious or chronic medical conditions.

_____
_____
_____
_____

3. Medications

Please list any known drug allergies and specific reaction

_____
_____

Please list all current medications with dosage and frequency (if you are using any diabetes and or thyroid related medications please list these first. Please include glucometer or continuous glucose monitor brand if you are diabetic).

_____
_____
_____
_____
_____
_____
_____
_____

For patients using an insulin pump -- please provide the following information:
Brand of pump:_____Date started:_____
Basal Insulin Rates:_____
_____
_____
Insulin/Carb Ratios: _____
_____
Insulin Correction Factors:_____

4. General History:
Marital Status (check one): ☐Single ☐Married ☐ Divorced ☐Widowed ☐
Occupation:_____
Number of Children and year of birth for each child:_____

Alcohol Intake (please check one)____No ____Yes ____
Number of drinks per day:_____ OR Number of drinks per week:_____

Smoking History (answer Y or N): ____ Never smoked____ Currently smoking ____
Age started_____How many cigarettes per day?_____Quit smoking____ Age started_____
Age stopped_____

Exercise (type and frequency)_____

5. Major Surgeries: Please list below. ☐Check if no history of major surgery.
_____Date_____
_____Date_____
_____Date_____
_____Date_____
1. Use this area if additional space is needed to list additional surgeries_____
_____
_____

6. Family History: ☐ Check if family history is unknown or no family history to report

Please check/ list all that apply	Father	Mother	Sibling (Specify brother or sister)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diabetes							
Thyroid Problems							
Heart Attack							
Cancer (if yes, please list type)							
High Blood Pressure							
Stroke							
Osteoporosis							
Kidney Disease or Kidney stone (specify)							
Other (please specify)							

Please list any other family history that you would like to report_____
_____
_____
_____

7. <u>Overall health review:</u> Please check all that apply

Constitutional: ☐ weight gain ☐ weight loss ☐ fatigue ☐ fever ☐ sleep problems

Endocrine: ☐ heat intolerance ☐ cold intolerance ☐ excessive thirst ☐ frequent urination ☐ nipple discharge ☐ irregular periods ☐ excessive facial or body hair (women)

Eyes: ☐ vision change ☐ double vision ☐ eye pain ☐ change in eye shape ☐ swelling of eyelids

Ears: ☐ ear pain ☐ hearing impairment ☐ ringing in ears

Nose: ☐ change in smell ☐ nosebleeds

Mouth/Throat: ☐ difficulty swallowing ☐ hoarseness ☐ voice changes ☐ neck masses

Cardiovascular: ☐ chest pain ☐ palpitations ☐ swelling

Respiratory: ☐ shortness of breath ☐ wheezing ☐ cough ☐ sleep apnea

Gastrointestinal: ☐ abdominal pain ☐ heartburn ☐ diarrhea ☐ constipation ☐ nausea ☐ vomiting

Genitourinary: ☐ frequent urination ☐ difficulty/pain urination ☐ unexplained bleeding

Musculoskeletal: ☐ musculoskeletal symptoms ☐ muscle pain ☐ joint pain

Skin: ☐ rash ☐ itching ☐ dry skin ☐ hives

Neurologic: ☐ headaches ☐ dizziness ☐ memory loss ☐ fainting ☐ numbness

Psychiatric: ☐ emotional problems or concerns ☐ depression ☐ anxiety

Hematologic/Lymphatic: ☐ night sweats ☐ easy bruising ☐ swollen lymph nodes ☐ easy bleeding tendency

8. I attest that the health information provided on this form is correct to the best of my knowledge

Signature of Patient:_____Date:_____
OR:
Signature of Authorized Representative_____Date:_____
Please print representative's name:_____
Relationship to patient:_____

Thank you for completing this health questionnaire intake form. The information provided will help Loudoun Endocrinology Associates better serve your health and endocrine related needs.