NEW PATIENT – ENDOCRINOLOGY (9/05)

(Please fill this form out completely.)

Name: ______________________________ **Appointment Date:** ___________________

Date of Birth: ________________________ **Primary Care Physician:** ______________

Home Phone: _________________________

Reason for Today's Visit: ____

Past Medical History: *(Check all that apply to you.)*

- ❑ Abnormal Pap Smear Details: _______________
- ❑ Acne Details: _______________
- ❑ Alcohol or substance abuse Details: _______________
- ❑ Anemia Details: _______________
- ❑ Anorexia Details: _______________
- ❑ Anxiety Disorder Details: _______________
- ❑ Asthma Details: _______________
- ❑ Atrial Fibrillation Details: _______________
- ❑ Bipolar Disorder Details: _______________
- ❑ Blocked Arteries Details: _______________
- ❑ Blood Clot Details: _______________
- ❑ Blood Transfusion Details: _______________
- ❑ Breast Cancer Details: _______________
- ❑ Breast Cyst Details: _______________
- ❑ Breast Lump Details: _______________
- ❑ Chronic Bronchitis Details: _______________
- ❑ Colitis Details: _______________
- ❑ Colon Polyps Details: _______________
- ❑ Congestive Heart Details: _______________
  Failure Details: _______________
- ❑ Depression Details: _______________
- ❑ Diabetes Details: _______________
- ❑ Diverticulitis Details: _______________
- ❑ Diverticulosis Details: _______________
- ❑ Emphysema Details: _______________
- ❑ Eczema Details: _______________
- ❑ Frequent Urinary Details: _______________
  Infections Details: _______________
- ❑ Gallstones Details: _______________
- ❑ Gout Details: _______________
- ❑ Heart Attack Details: _______________
- ❑ Heart Disease Details: _______________
- ❑ Hepatitis Details: _______________
- ❑ High Blood Pressure Details: _______________
- ❑ High Cholesterol Details: _______________
- ❑ High Triglycerides Details: _______________
- ❑ Hypothyroidism Details: _______________
- ❑ Irritable Bowel Details: _______________
  Syndrome Details: _______________
- ❑ Kidney Stones Details: _______________
- ❑ Lupus Details: _______________
- ❑ Melanoma Details: _______________
- ❑ Migraine Details: _______________
- ❑ Morbid Obesity Details: _______________
- ❑ Non-Melanoma Skin Details: _______________
  Cancer Details: _______________
- ❑ Osteoarthritis Details: _______________
- ❑ Osteopenia Details: _______________
- ❑ Osteoporosis Details: _______________
- ❑ Other blood disorder Details: _______________
- ❑ Other cancer Details: _______________
- ❑ Other kidney disease Details: _______________
- ❑ Pneumonia Details: _______________
- ❑ Positive TB skin test Details: _______________
- ❑ Prostate BPH Details: _______________
- ❑ Prostate Enlargement Details: _______________
- ❑ Prostate cancer Details: _______________
- ❑ Prostate Problems Details: _______________
- ❑ Psoriasis Details: _______________
- ❑ Reflux (GERD) Details: _______________
- ❑ Rheumatic Fever Details: _______________
- ❑ Rheumatoid Arthritis Details: _______________
- ❑ Rosacea Details: _______________
- ❑ Seasonal Allergies Details: _______________
- ❑ Seborrheic Dermatitis Details: _______________
- ❑ Seizures Details: _______________
- ❑ Stroke Details: _______________
- ❑ Thyroid Disorder Details: _______________
- ❑ Tuberculosis Details: _______________
- ❑ Ulcer Details: _______________
- ❑ Valve problem/Murmur Details: _______________
- ❑ Warts Details: _______________

Past Surgical History:
(check all that apply)

What year, etc.:

- ❑ No past surgeries.
- ❑ Appendectomy
- ❑ Arthroscopy
- ❑ Caesarean section
- ❑ Cataract Surgery
- ❑ Cervical Laminectomy
- ❑ Cholecystectomy
- ❑ Colectomy
- ❑ Coronary Artery Bypass
- ❑ Hemorrhoidectomy
- ❑ Herniorraphy inguinal
- ❑ Hysterectomy
- ❑ Lumbar Laminectomy
- ❑ Mastectomy
- ❑ Polypectomy
- ❑ Tonsillectomy/ adenoidectomy
- ❑ Total Hip Replacement
- ❑ Total Knee Replacement
- ❑ TUR Prostate
- ❑ Vasectomy
- ❑ OTHER:

REPRODUCTIVE HISTORY:

What age did you begin having menstrual periods? ___________

# of Pregnancies: ___________

# of Births: ___________

# of Miscarriages: ___________

# of Abortions: ___________

Date of last menstrual period: ___________

Contraception Method: ___________

Date of last pap smear: ___________

Date of last mammogram: ___________

Have you had a bone density test? ❑ Yes ❑ No

REVIEW OF SYSTEMS:

In general, how do you feel? ____________________

How is your energy level? ____________________

Has your weight fluctuated more than 10 pounds in the past year? ❑ YES ❑ NO

If yes, how much? ____________________

Have you had any fever, chills or night sweats? ❑ YES ❑ NO

HEENT:

Any significant changes in vision? ❑ YES ❑ NO

Hearing? ❑ YES ❑ NO

Any pollen allergies or bad nasal drainage? ❑ YES ❑ NO

❑ Other: ____________________

RESPIRATORY:
(check all that apply)

- ❑ chronic cough
- ❑ chest congestion
- ❑ shortness of breath
- ❑ coughing up of blood
- ❑ other: ____________________

CARDIOVASCULAR:
(check all that apply)

- ❑ chest pain
- ❑ chest pressure or tightness
  If so, what brings it on? ____________________
- ❑ heart palpitations or irregular heart beat
- ❑ edema or swelling
- ❑ leg cramps with walking

GI: ***(check all that apply)***

- ❑ chronic or severe indigestion
- ❑ pain or difficulty swallowing
- ❑ nausea or vomiting
- ❑ change in bowel habits, diarrhea or constipation
- ❑ blood in stool

GU: ***(check all that apply)***

- ❑ burning with urination
- ❑ difficulty urinating
- ❑ blood in urine
- ❑ increased frequency of urination
- ❑ leakage of urine

Frequency of night time urination: ___________

MUSCULOSKELETAL:

Any chronic or bothersome arthritis or joint pain? ❑ YES ❑ NO
If yes, which joints? ____________________
Any chronic or severe back pain? ❑ YES ❑ NO
Any unusual muscle aches or cramping? ❑ YES ❑ NO

SKIN:

Any skin lesions that are growing, changing or need attention? ❑ YES ❑ NO
What area? ____________________

SLEEP:

Are you sleeping well? ❑ YES ❑ NO
Number of hours per night you sleep: ____________________

PSYCHOLOGIC:

Is your stress level: ❑ High ❑ Low ❑ Avg
Any feelings of anxiety, depression or nervousness? ❑ YES ❑ NO

NEUROLOGIC:

Any chronic or unusual headaches? ❑ YES ❑ NO
Any numbness or tingling? ❑ YES ❑ NO
Any lightheadedness, dizziness or fainting spells? ❑ YES ❑ NO

MEN:

Do you do monthly self-testicular exams? ❑ YES ❑ NO
Any lumps or pain noted? ❑ YES ❑ NO
Any impotence or sexual dysfunction? ❑ YES ❑ NO
Medical treatment desired? ❑ YES ❑ NO

WOMEN:

Do you perform monthly self-breast exams? ❑ YES ❑ NO
Any breast pain, discharge or lumps? ❑ YES ❑ NO
Regular menstrual periods? ❑ YES ❑ NO
Date of last period: ____________________
Any vaginal discharge, discomfort or unexpected bleeding? ❑ YES ❑ NO
Pain with intercourse? ❑ YES ❑ NO
Method of contraception: ____________________
Date of menopause or hysterectomy? ____________________
Any impotence or sexual dysfunction? ❑ YES ❑ NO
Other: ____________________

OTHER:

____

____

____

____

Periodic Health Screening
When was your last:

Mammogram: __________ Pap Smear: __________ Colon Exam: __________
Flu Vaccine: __________ Tetanus Vaccine: __________ Pneumonia Vaccine: __________
Bone Densitometry: __________ Prostate Exam: __________ Dilated Eye Exam: __________
Other: ____________________

Family Medical History

	Living	Deceased	Age		Number Living	Deceased
Mother	☐	☐	____	Brothers:	_____	_____
Father	☐	☐	____	Sisters:	_____	_____

Have any members of your family had any of the following diseases?

Relationship:

☐ High blood pressure ☐ Stroke ☐ Diabetes ______________________________

☐ Heart Attack ☐ Other Heart Disease ______________________________

☐ Cancer, Type: ______________________________ ______________________________

☐ Hereditary or Genetic Disorders: ________________ ______________________________

Lifestyle and Social History: (Please check those that apply to you or fill in the blanks)

Marital Status: ☐ Single ☐ Married: (# of Times _____ How long? _____)
☐ Divorced ☐ Separated ☐ Widowed
# of children? _____ Who do you live with? _______________
What is the highest level of education you completed? ☐ Elementary ☐ Jr. High ☐ High School ☐ College ☐ Post-Grad
Current Occupation: ________________________________ How many hours per week? __________
Diet/Special Diet: ____________________Exercise (Type & Frequency): __________________________
Hobbies and Interests: ____
Caffeine? ☐ YES ☐ NO How many cups per day? __________
Do you use tobacco products? ☐ YES ☐ NO Type: _______________ For how long? ___________
How much? __________ If you quit, when? __________ Are you interested in quitting? __________
Alcohol Intake: ☐ None ☐ Occasional ☐ 1-2 drinks per day ☐ More than 2 drinks per day
Drugs: ☐ None ☐ Rarely ☐ Occasional ☐ Daily Type: _______________ Quit: __________
Do you feel your life is stressful? ☐ YES ☐ NO Source of stress: ______________________
How many hours do you sleep per night? __________ % of time you wear seatbelts: ____________

Medications Please list all prescription drugs you are currently taking:

	Drug	Strength	Frequency		Drug	Strength	Frequency
1.				6.			
2.				7.			
3.				8.			
4.				9.			
5.				10.			

Please list all over the counter medications you take: ____
____

Do you have any drug allergies? ____
List drug and type of reaction: ____