Center for Endocrine Health Medical History

Please complete this to the best of your ability

Do you or have you ever had any of the following problems?

	Yes	No	Not sure
Diabetes	☐	☐	☐

If yes, list any complications, eg eye, kidney, nerve or foot problems:___________________________

Last eye exam:___________________________

	Yes	No	Not sure
Heart Disease	☐	☐	☐
High Blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
Thyroid disease	☐	☐	☐
Pituitary problems	☐	☐	☐
Adrenal problems	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐
Fracture including compression fractures	☐	☐	☐
Kidney Stones	☐	☐	☐
Menstrual problems	☐	☐	☐

Other medical conditions not listed above:

________________________ ____________________________ _________________________

________________________ ____________________________ _________________________

Surgeries ______________________ _________________________ ______________________

________________________________ ________________________ ________________________

Current Medications and Doses: Please bring a list of medications and dosages with you to the appointment.

Drug Allergies: ____

Family History:
Have any members of your immediate family (parents, maternal/paternalgrandparents and siblings) had any of the following conditions:

	Yes	No	Not sure	Who ?
Diabetes	☐	☐	☐	______________________
Heart disease	☐	☐	☐	______________________
Stroke	☐	☐	☐	______________________
High cholesterol	☐	☐	☐	______________________
High blood pressure	☐	☐	☐	______________________
Osteoporosis	☐	☐	☐	______________________
Kidney stones	☐	☐	☐	______________________
Thyroid disease	☐	☐	☐	______________________
Cancer (list type)	☐	☐	☐	______________________

Other important family medical history____

Social history: mark the appropriate box

☐Married ☐Single ☐Divorced ☐Widowed ☐In a significant relationship

☐Children: #_____________________________

☐Regular exercise - what form and how many days a week________________________________

☐Currently working - what is your occupation____

☐Retired – Previous occupation____

☐Unemployed – Previous occupation____

☐Disabled – due to ____

Tobacco use: ☐Never, ☐Past, if so last quit date ___________, smoked for ___________#yrs

☐Current Use # of cigarettes a day_________________________________

Alcohol use: ☐Never, ☐Rare, ☐Occasional (< 3 drinks a week), ☐regular (>3 drinks a week)
drinks per week _____________________________

History of illicit drug use: ☐Never, ☐Past, ☐Current -provide details_________________________

In the **past 6 months** have you experienced any of the following symptoms?

☐Weight loss	☐Weight gain	☐Loss of appetite
☐Night sweats	☐Fatigue	☐Fever/Chills
☐Blurred/double vision	☐Hearing loss	☐Ear pain
☐Hoarseness	☐Difficulty swallowing	☐Neck pain
☐Chest pain	☐Palpitations	☐ Pain in your calves
☐Leg swelling	☐Shortness of breath	☐Cough
☐Diarrhea	☐Constipation	☐Abdominal pain
☐Bloating	☐Heartburn	☐Nausea/vomiting
☐Irregular menstrual cycles	☐Painful menstrual cycles	☐Heavy menstrual bleeding
☐Pain with intercourse	☐ Low sex drive	☐Difficulty with erections
☐Frequent urination	☐Painful urination	☐Getting up to urinate at night , #times___
☐Skin rash	☐Nipple discharge	☐Breast pain
☐Headache	☐Sensation/nerve problems	☐Seizures
☐Weakness	☐Tremor of hands	☐Poor balance/falls
☐Change in size of hands/feet	☐Unwanted facial/body hair	☐Intolerance of hot weather
☐Intolerance of cold weather	☐Increased thirst	☐Increased hunger
☐Hot flashes	☐Excessive sweating	☐Stretch marks
☐Seasonal allergies	☐Perennial allergies	☐Food allergies
☐Depression	☐Crying spells	☐Anxiety
☐Irritability	☐Mood changes	☐Suicidal thoughts
☐Insomnia	☐Snoring	☐Hypersomnia (excessive sleep)
☐easy bruising	☐hair loss	☐swollen glands

Please list any other symptoms which you believe to be of importance:

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