ENDOCRINE AND DIABETES CARE CENTER

MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release this.

PLEASE PRINT AND COMPLETE ALL INFORMATION

Last Name	First	Middle	Today's Date ____/____/____	Birthdate ____/____/____

Family History	If Living Age	If Living Health (Good Fair Poor)	If Deceased Death Age	If Deceased Death Cause
Father				
Mother				
Brother Sister (circle sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
[] Husband [] Wife				
Sons Daughters (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Any blood relatives who have or have had any of the listed conditions

(check)	Yes	No	Relationship	(check)	Yes	No	Relationship
Adrenal Tumor				Obesity			
Asthma				Osteoporosis			
Arthritis				Pancreas Tumor			
Anemia				Pituitary Tumor			
Bleeding Tend				Stroke			
Cancer				Suicide			
Colitis				Stomach Ulcers			
Congenital Heart				Other:			
Diabetes							
High Bl Press							
High Cholesterol				**THYROID**			
Heart Disease				Enlarged (goiter)			
Kidney Disease				Overactive Thyroid			
Kidney Stones				Underactive Thyroid			
Leukemia				Thyroid Tumor			
Mental Illness				Thyroid Cancer			

MEDICATIONS: LIST OF ALL MEDICATIONS AND DOSES YOU ARE CURRENTLY TAKING INCLUDING OVER THE COUNTER OR HERBAL

1.	6.	11.	16.
2.	7.	12.	17.
3.	8.	13.	18.
4.	9.	14.	19.
5.	10.	15.	20.

DRUG ALLERGIES AND FOOD ALLERGIES:

HOSPITALIZATIONS AND SERIOUS ILLNESS:

Operations you have had:	Year	Diseases you have had requiring hospitalization:	Year
1.		1.	
2.		2.	
3.		3.	
Serious Illness not requiring hospitalization:	**Year**	**Serious Injuries or Accidents:**	**Year**
1.		1.	
2.		2.	
3.		3.	

Habits:

Do You:	Check One		Daily Consumption
Smoke.....	[] Yes	[] No	Packs: _____
Drink Coffee.....	[] Yes	[] No	Cups: _____
Drink Alcohol.....	[] Yes	[] No	Ounces: _____
Drink Beer.....	[] Yes	[] No	Ounces: _____
Fall Asleep Easily.....	[] Yes	[] No	
Awaken Early.....	[] Yes	[] No	

Women Only:

Are you still having monthly periods?.....	[] Yes [] No	
Date of last menstrual period:.....	___/___/___	
Are you now or ever taken birth control pills?..	[] Yes [] No	When?
How many children born alive?.....	_____	
How many pregnancies?.....	_____	
Have you ever had a miscarriage?....	[] Yes [] No	When?
Do you regularly have a Pap Test?...	[] Yes [] No	Date:

MEN Only:

Have you had:	Check	For How Long?
Loss of sexual activity?	[] Yes [] No	
Discharge from penis?	[] Yes [] No	_____
Hernia (rupture?)	[] Yes [] No	_____
Prostate trouble?	[] Yes [] No	_____

WOMEN AND MEN

HAVE YOU NOTED:	Check
Excessive hair loss?	[] Yes [] No
Unusual hair growth?	[] Yes [] No
Skin dryness or oily skin?	[] Yes [] No
Changes in skin pigmentation?	[] Yes [] No

MEN AND WOMEN:

HAVE YOU RECENTLY EXPERIENCED:			Check
Weight loss?	How much?	Since when?	[] Yes [] No
Weight gain?	How much?	Since when?	[] Yes [] No
Loss of energy?			[] Yes [] No
Sleep more than usual?			[] Yes [] No
Loss of appetite?			[] Yes [] No
Increased thirst?			[] Yes [] No
Increased amount of urine?			[] Yes [] No
DO YOU HAVE?			
Frequent headaches?			[] Yes [] No
Spells of dizziness?			[] Yes [] No
Seizures or convulsions?			[] Yes [] No
Spells of weakness of an arm or leg?			[] Yes [] No
Hearing loss?			[] Yes [] No
Ringing in ears?			[] Yes [] No
Nosebleeds?			[] Yes [] No
Bleeding gums?			[] Yes [] No
Hoarseness?			[] Yes [] No
A sore tongue?			[] Yes [] No
DO YOU HAVE?			
Difficulty swallowing			[] Yes [] No
Nausea or vomiting?			[] Yes [] No
Pain in the abdomen?			[] Yes [] No
Diarrhea?			[] Yes [] No
Constipation?			[] Yes [] No
Blood in stools?			[] Yes [] No
DO YOU HAVE:			
Joint pain?			[] Yes [] No
Joint swelling?			[] Yes [] No
Stiffness of joints?			[] Yes [] No
Back pain?			[] Yes [] No
Difficulty walking?			[] Yes [] No

HAVE YOU NOTED:	
Double Vision?	[] Yes [] No
Blurring?	[] Yes [] No
Visual Loss?	[] Yes [] No
HAVE YOU RECENTLY HAD:	
Shortness of breath?	[] Yes [] No
Wheezing?	[] Yes [] No
Cough?	[] Yes [] No
Pain in your chest?	[] Yes [] No
Palpitations?	[] Yes [] No
Sweating of hands, feet or legs?	[] Yes [] No
HAVE YOU NOTED:	
Frequent urination?	[] Yes [] No
Burning when urinating?	[] Yes [] No
Loss of control of bladder?	[] Yes [] No
Blood in the urine?	[] Yes [] No
Dark colored urine?	[] Yes [] No
Trouble starting to urinate?	[] Yes [] No
Gravel or sand like or a stone in the urine?	[] Yes [] No
DO YOU HAVE:	
Numbness or tingling in hands or feet?	[] Yes [] No
Weakness of arms or legs?	[] Yes [] No
Burning like feeling in feet?	[] Yes [] No
Phlebitis or inflamed leg veins?	[] Yes [] No
Varicose veins?	[] Yes [] No
Ulcers in your legs or feet?	[] Yes [] No
Pain in calves of legs when walking?	[] Yes [] No
HAVE YOU NOTED:	
Nervousness?	[] Yes [] No
Shakiness?	[] Yes [] No
Sweating?	[] Yes [] No
Personality changes?	[] Yes [] No
Memory loss?	[] Yes [] No

DESCRIBE BRIEFLY YOUR PRESENT MEDICAL SYMPTOMS AND ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR HEALTH: