Name:

Date:

DOB:

Adult Medical History Form

Welcome to our practice. To provide you with the best care possible, we request that you provide the following information. Your answers on this form will help the doctor understand your medical concerns and conditions better. This form will be reviewed and kept as a part of your confidential medical record unless you desire otherwise. If you are uncomfortable with a question, do not answer it. If you cannot remember specific, please use your best estimate.

What was the problem for which you were referred to Endocrinology?

PERSONAL MEDICAL HISTORY (indicate if you have the following with YEAR OF DIAGNOSIS)

Medical Problem	Year of Diagnosis/ Details	Medical Problem	Year of Diagnosis/ Details
□ High Blood Pressure		□ Osteoporosis	
□ High Cholesterol		□ Broken Bone	
□ Heart Attack		□ Liver problems/Hepatitis	
□ Stroke		□ Bleeding Problems	
□ Atrial Fibrillation		□ Intestinal Problems	
□ Celiac Disease		□ Thyroid Problem	
□ Cancer		□ Emphysema/COPD	
□ Depression / Anxiety		□ Asthma	
□ Kidney Disease		□ Smoking	
□ Kidney Stones		□ Alcoholism	

Other Problems: _____

_____

_____

SURGICAL HISTORY (list all procedures and operations with year)

Procedure/Surgery	Year	Procedure/Surgery	Year

WOMEN- Menstrual /Pregnancy history

Age of 1st menstruation:_____ Frequency of periods:_____ Length of period: _____ Menopause age: _____

#of Pregnancies:_____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Other female problems _____

If menopausal, using / used Estrogen / Progesterone treatment: Never / Yes. Details: _____

FAMILY HISTORY	**Age**	**Age of Death**	**Cause of Death and/or Medical Problems**
Mother:			
Father:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			

Name:

Date:

SOCIAL HISTORY

Tobacco Use: □ Never □ Quit (Year: ____, After using for_____yrs)

□ Current: # packs/day _____ , # of years _____

Alcohol Use: □ Never □ Quit (Year:_____)

□ Drink _#_____ drinks per day / week / month / year (please circle one)

Drug Use: □ Current □ Never □ Quit (Year:_____) What used?:_____

Have you ever used injectable (i.e. IV) recreational drugs □ Yes □ No

Marital Status: □ Married □ Single □ Separated □ Domestic Partner □ Other: _____

□ Widowed- what year? _____

Sexual Activity: Sexually active? □ Yes □ No □ Not Currently

Current partner is □ Male □ Female

Birth control method (if applicable): _____

Retired? Yes / No. Current or Past Occupation: _____

Highest level of school completed:_____

MEDICATION ALLERGIES / INTOLERANCES: □ NONE

Drug	Reaction	Drug	Reaction

CURRENT MEDICATIONS

Drug	Dose (pill size?)	Dose (amount & frequency)
□ Aspirin	□ 81mg □325 mg	□ One tab once daily □ One tab twice daily _

Current Symptom Review

Rate average energy past week (1=low, 10= high): _____/10

	Symptoms		No Problem	Issue details: circle one N =new, C = chronic. → **Please provide details /changes.**
a)	Fevers/ Sweats	a)		N / C →
b)	Intolerance of cold	b)		N / C →
c)	Intolerance of heat	c)		N / C →
d)	Vision change	d)		N / C →
e)	Sinus or ear symptoms	e)		N / C →
f)	Chest Pains	f)		N / C →
g)	Heart Racing	g)		N / C →
h)	Leg swelling (edema)	h)		N / C →
i)	Shortness of breath	i)		N / C →
j)	Cough	j)		N / C →
k)	Nausea or Vomiting	k)		N / C →
l)	Abdominal Pain	l)		N / C →
m)	Discomfort w/ urination	m)		N / C →
n)	Joint Pains	n)		N / C →
o)	Balance problems / Falls	o)		N / C →
p)	Difficulty with memory	p)		N / C →
q)	Tremor	q)		N / C →
r)	Headaches	r)		N / C →
s)	Skin rash or skin lesions	s)		N / C →
t)	Hair Loss	t)		N / C →
u)	Bleeding / Bruising	u)		N / C →
v)	Allergies	v)		N / C →
w)	Insomnia	w)		N / C →
x)	Anxiety	x)		N / C →
y)	Depression	y)		N / C →
z)	Men:Erectile dysfunction	z)		N / C →

Bowel Movements: Per day _____ OR Per week _____

Urinating at night: none OR # per night _____