THE ENDOCRINOLOGY GROUP HEALTH HISTORY FORM

Patient FULL Name: _____

How do you wish to be addressed:_____ Pronouns *(circle all that apply)*: He/Him She/Her They/Them

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer them. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit:

Please add any information about your health that you would like your provider to know:

Allergies: _____

List anything that you may be allergic to (medications, food, bee stings, etc) and how each affects you

Past Medical History *(circle all that apply)*

Anemia	Coronary Artery Disease	High Blood Pressure	Lung Disease
Anxiety Disorder	Depression	Heart Murmur	Osteoporosis
Asthma	Diabetes Insulin / Non-Insulin	Thyroid Disease:	Reflux / Ulcers
Blood Clots (or DVT)	Eye Disease	Hypothyroid / Hyperthyroid	Stroke (CVA)
Cancer & Type:	Heart Attack	Kidney Disease / Stones	Vitamin D
_____	HIV or AIDS	Leg / Foot Ulcers	Other: _____
	High Cholesterol	Liver Disease	

Obstetric and Gynecological History *(for women only)*

Date of last menstrual period: _____ Number of Pregnancies: _____ Births: _____

FAMILY Health History

☐ **No significant family history is known**

	Relation (mother, father, sibling, MGM/MGF, PGM.PGF, etc)		**Relation**		**Relation**
Coronary Artery Disease		Depression / Anxiety		Thyroid Disease	
Cancer & type		Heart Disease		Osteoporosis	
Diabetes		Stroke		Other disease	

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Have you recently had problems with any of the following:

GENERAL

Weight loss	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Decr. appetite	☐ Yes	☐ No
Fevers	☐ Yes	☐ No

HEAD, EYES, EARS, THROAT

Headache	☐ Yes	☐ No
Blurred vision	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Problems hearing	☐ Yes	☐ No
Voice changes	☐ Yes	☐ No
Neck swelling	☐ Yes	☐ No
Swallowing problems	☐ Yes	☐ No

HEART

Chest pain or discomfort	☐ Yes	☐ No
Racing heart beats	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No
Leg pain w/ walking	☐ Yes	☐ No

RESPIRATORY

Cough	☐ Yes	☐ No
Short of Breath	☐ Yes	☐ No

SKIN/BREASTS

Rashes	☐ Yes	☐ No
Vitiligo (white skin changes)	☐ Yes	☐ No
Breast tenderness	☐ Yes	☐ No
Breast fluid leakage	☐ Yes	☐ No

GASTROINTESTINAL

Abdominal pain	☐ Yes	☐ No
Change in bowel	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No

GENITOURINARY

Urinary difficulties	☐ Yes	☐ No
Nighttime urination	☐ Yes	☐ No

WOMEN ONLY

Change in your periods	☐ Yes	☐ No
Low sexual desire	☐ Yes	☐ No

MEN ONLY

Problems w/erections	☐ Yes	☐ No
Pain/lump in testicles	☐ Yes	☐ No
Low sexual desire	☐ Yes	☐ No

MUSCULAR SKELETAL

History of broken bones	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Gout	☐ Yes	☐ No

PSYCHIATRIC

Depressed mood	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Problems sleeping	☐ Yes	☐ No

NEUROLOGY

Dizziness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tingling sensations	☐ Yes	☐ No

ENDOCRINE

Problems with heat	☐ Yes	☐ No
Problems with cold	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Frequent urination	☐ Yes	☐ No
Changes in hair	☐ Yes	☐ No

SOCIAL History *(circle all that apply)*

Tobacco Use Everyday Someday Former (Quit date _____) Never Passive (2nd hand smoke)

If Current smoker: # of pkg/day _____ # of years _____

Other tobacco: Cigar Chew Vape

Alcohol # of Drinks/week: ___Glasses of wine ___Cans of beer ___Shots or Liquor ___Drinks containing 0.5oz of Alcohol

4 or more drinks on one occasion? Never Less than monthly Monthly Weekly Daily or Almost daily

Drug Use Marijuana Cocaine Methamphetamines None Other: _____

How often do you drink caffeine? None Moderate Occasional Heavy If so? # of cups/cans per day: _____

Education Years of Educations / highest degree: _____

Occupation _____ Unemployed Retired Disabled LOA

Marital Status Single Domestic Partner Married Separated Divorced Widowed Other _____

# of Children / ages: _____ **Who lives at home with you?** _____