Endocrine Specialists of Atlanta

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Date _____ Patient name _____ Age_____

Date of Birth _____ Referring physician _____

MEDICATIONS: List all your medications, including over the counter, vitamins, food supplements.
(If there is not enough room, please use the available space on the 2nd page.)

	NAME OF DRUG	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

LIST YOUR DRUG ALLERGIES WITH SYMPTOMS YOU EXPERIENCED:

_____

_____

_____

_____

LIST ALL HOSPITALIZATIONS, SURGERIES, ACCIDENTS/INJURIES: (If there is not enough room, please use the available space on the 2nd page)

DATE	DIAGNOSIS	LOCATION

975 Johnson Ferry Road, Suite 400,
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MEDICAL HISTORY QUESTIONNAIRE

Social History

Place of birth _____
Marital Status (duration and number of marriages if applicable) _____
Number of children and ages _____
Highest level of education completed and degree _____
Occupations _____
Hazardous exposures at work or at home _____
Pets and other animals exposed to _____
Travel outside U.S. in past 5 years _____
Tobacco usage (current or past) _____ Amount/Duration _____ If applicable, date of cessation _____
Caffeine usage _____ How much per day _____
Alcohol usage _____ How much per week _____
Recreational drug usage _____ Which type and how much per week _____
Exercise: How many times per week _____ Type of exercise _____ How many minutes _____

Family History

Do any of your close relatives have the following conditions:

	Yes	No	Relatives
Heart disease	_____	_____	_____
High blood pressure	_____	_____	_____
Stroke	_____	_____	_____
High Cholesterol	_____	_____	_____
Diabetes	_____	_____	_____
Thyroid disease	_____	_____	_____
Kidney stones	_____	_____	_____
Osteoporosis	_____	_____	_____
Mental illness	_____	_____	_____
Bleeding disorder	_____	_____	_____
Anemia	_____	_____	_____
Colon cancer	_____	_____	_____
Ovarian cancer	_____	_____	_____
Breast cancer	_____	_____	_____
Prostate cancer	_____	_____	_____
Alcoholism	_____	_____	_____

Immunizations
(in past 10 years)
(Put Date of the Last Shot)

Measles/MMR _____
Tetanus/DPT/DT _____
Hepatitis _____
Flu _____
Pneumonia _____
Other _____

List the following information on your immediate family:

Family member	Age	If not living, age at death	Cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)/Sister(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

_____
_____
_____
_____

REVIEW OF SYSTEMS

Please circle any of the following symptoms which you have experienced in the last two weeks.

SYMPTOM

General

Fever
Fatigue
Weight change >10lbs.
Difficulty Sleeping
Mumps
Measles
HIV infection
Blood transfusion
Breast implants
Alcoholism
Chills
Sweats
Appetite Change
Anemia
Excessive daytime sleepiness

Pulmonary

Cough
Coughing up blood
Coughing up mucous
Bronchitis
Pneumonia
Pleurisy
Wheezing
Asthma
Positive TB skin test
Tuberculosis
Previous chest x ray _____(date)

Musculoskeletal

Pain in muscles/joints
Join swelling
Muscle cramps
Arthritis
Joint stiffness
Back pain
Handicapped
Gout
Previous bone density _____(date)

SYMPTOM

Eyes, Ears, Nose, Throat

Sinusitis
Change in vision
Color blindness
Night blindness
Blurred vision
Double vision
Peripheral vision change
Ear pain
Difficulty hearing
Noises in ears
Previous eye exam _____(date)
Previous dental exam _____(date)
Hayfever/Allergies
Dizziness/Vertigo
Snoring

Cardiovascular

Palpitations
High blood pressure
Chest pain
Heart disease
Heart murmur
Mitral valve prolapse
Shortness of breath
Swelling
Blue fingers or toes
Phlebitis/blood clots
Leg pain with walking
Previous EKG _____(date)
Previous treadmill test _____(date)
Rheumatic Fever
Pacemaker
Passing out

Reproductive (male)

Penile discharge
Penile pain
Lumps in testicles
Painful testicles
Large prostate
Prostatitis
Prostate cancer
Impotence
Cannot have erections
Lack of sexual desire
Cannot have orgasms
Sexually transmitted diseases
Hernia
Last PSA _____(date) and level _____

SYMPTOM

Skin

Color/texture change
change in hair or nails
Rashes
Itching
Easily bruised
Hives
Frequent skin infections
Eczema
Psoriasis
Skin Cancer

Urinary

Excessive urination
Urination at night
Pain with urination
Urge to urinate
Urinary tract infection
Kidney stones
Leakage of urine
Change in urine stream
Trouble starting stream
Blood in urine
Brown urine

Neurological

Weakness
Stroke
Paralysis
Difficulty speaking
Seizures
Headaches
Change in sensation
Numbness, tingling
Feeling Faint
Change in handwriting
Tremor
Anxiety
Phobias
Hallucinations
Depression
Psychiatric treatment
Suicide attempt
Thoughts of suicide
Physical/Sexual abuse
Memory Loss

Gastrointestinal

Food intolerance
Problems with teeth/gums
Abnormal taste
Sore tongue
Trouble swallowing
Heartburn
Stomach pain
Excessive belching
Bloating
Nausea
Vomiting
Vomiting blood
Ulcers
Hepatitis/Jaundice
Gallbladder disease
Hemorrhoids
Pancreatitis
Inflammatory Bowel
Spastic colon
Change in stool
Black stool
Blood in stool
Diarrhea
Constipation
Excessive gas
Lactose intolerance
Reflux
Hiatal Hernia
Previous colonoscopy/sigmoidosopy _____(date)

Endocrine

Ring size change
Shoe size change
Abnormal sweating
Change in appetite
Breast milk
Head/neck irradiation
Thyroid disease
Goiter/enlarge thyroid
Cold intolerance
Heat intolerance
Trouble losing weight
Excessive hair growth
Loss of hair
Acne
Breast enlargement
Excessive hunger
Excessive thirst
Excessive urination
Sugar in the urine
Diabetes
High blood calcium
Low blood calcium
Osteoporosis
Gestational Diabetes

Reproductive (female)

Age you first started your period _____
Date of your last menstrual period _____
How many pregnancies have you had? (Including unsuccessful and successful pregnancies) _____
Weight(s) of newborns? _____
How many pregnancies went to term? _____
How many pregnancies were premature? _____
How many miscarriages/abortions have you had? _____
Any complications with any pregnancy? _____
Date of hysterectomy _____ Were your ovaries also removed? _____
Last Pap test _____ Last Mammogram _____

(Circle any of the following, which are chronic or recurrent problems)

Change in periods
Hot flashes/flushes
Sweats
Vaginal dryness
Vaginal infections
PMS
Pain with intercourse
Infertility
Change in sexual desire
Sexually transmitted disease
Breast lumps
Breast pain
Breast discharge
Breast cancer
Wetting of pants

MEDICAL HISTORY QUESTIONNAIRE