OHIOHEALTH ENDOCRINOLOGY MEDICAL HISTORY FORM

PERSONAL INFORMATION (PLEASE PRINT)

FULL NAME: _____ **TODAYS DATE** _____

ADDRESS: _____ CITY**:** _____ **ST:** _____ **ZIP** _____

HOME PHONE: (____) _____ _____ **BUSINESS PHONE**: (____) _____ CELL **PHONE:** (____)_____

SOCIAL SECURITY #: _____ SEX**: MALE/FEMALE** **MARITAL STATUS** _____

AGE: _____ DATE **OF BIRTH**:_____ **PLACE OF BIRTH** (CITY, STATE, COUNTRY, REGION) _____

RACE/NATIONALITY: _____ **RELIGION:** _____

OCCUPATION: _____ **EMPLOYER**: _____

EMERGENCY CONTACT NAME: _____ **PRIMARY PHONE#:** (____)_____

SECONDARY PHONE #: (_____)_____ **RELATIONSHIP TO PATIENT**:_____

May we leave message on your answering machine/voicemail? _____ yes _____ no

Please provide name(s) of individuals with contact information and relationship to you for individuals we may talk to in reference to your medical information:

NAME: _____ RELATIONSHIP _____ PHONE #: (____)_____

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Our office utilizes an automated calling system for appointment and account reminders. If you do not wish to be contacted by out automated system please advise our front desk personnel and we will remove your telephone number from our system.

Patient or responsible party: _____ _____ _____

(Print Name) (Signature) (Date)

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected at the time of check in. We accept payment in the form of cash, check or credit cards. In the event that your check is returned unpaid, you will be charged an equal amount to all bank charges that we incur in relation to this transaction. It is your responsibility to verify your participation with your insurance plan and that of any providers prior to your visit by contacting your insurance carrier.

PATIENT OR RESPONSIBLE PARTY: _____ _____ _____

(Print Name) (Signature) (Date)

Primary Care Physician _____

Referring Provider _____

Please briefly describe the reason you have come to see the endocrinologist today.

_____
_____
_____
_____

ALLERGIES:

Please list any allergies or sensitivities (list the medication/substance and the reaction):

_____
_____

PAST MEDICAL HISTORY:

List any past medical history and diagnosed medical conditions:

_____
_____
_____
_____

Previous Operations: (type of operation, date of surgery, hospital and name of surgeon)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Other reasons you have been hospitalized (include reason for hospitalization and year)

_____
_____
_____

Menstrual/Obstetric History (women only):

Date of last period _____ Are your periods regular or irregular? _____

Number of pregnancies _____ Number of miscarriages _____

Were you able to successfully breastfeed? _____

FAMILY HISTORY:

Please indicate the health of your immediate family below:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Siblings* (circle sex)				
M/F				
M/F				
M/F				
M/F				
Husband/Wife				
Children* (circle sex)				
M/F				
M/F				
M/F				
M/F				

Please indicate any blood relative who have/had the following conditions:

Diabetes_____ Obesity _____ Cancer _____

Heart disease _____ Hypertension _____ Pituitary disease_____

Adrenal gland disease_____ Auto-immune disease_____ High calcium levels _____

Thyroid cancer _____ Infertility problems_____ Osteoporosis _____

Thyroid disease_____ Kidney stones _____

SOCIAL HISTORY:

Do you currently use tobacco? If yes, please list type of tobacco used, how long you have smoked, and daily amount used. _____

If you have quit smoking, please list how long you smoked and your quit date.

_____

Do you currently drink alcoholic beverages? If yes, please list type of alcohol and amount per week consumed.

_____

Do you have a history of heavy alcohol use? If yes, please explain.

_____

Have you ever used marijuana? If yes, when was the last time you used it?

_____

Do you currently use any other "street" drugs? If yes, please list the drug(s) and the last time you used it.

_____

Current Medications: Prescription and Non-Prescription (including over the counter meds)

Medication Name Dose Amount How often taken

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Do you use any over the counter supplements not listed above? If yes, please list:

_____

_____

Are you taking Biotin or a hair/nail supplement? If yes, please list:

_____

_____

Have you ever used products/medications from a compounding pharmacy? If yes, please explain:

_____

_____

Have you taken any steroids or cortisone (pills, injections, inhalers, creams) in the last year? Please list type and dates of exposure:

_____

_____

Have you used estrogen products or oral contraceptives in the last year? If yes, please list type and last time taken:

_____

_____

Have you ever used the following medications: **Amiodarone, Hydrochlorothiazide, Lithium, Narcotic pain medications**? If yes, please list medication and last time taken:

_____

_____

Do you use any of the following: **Multivitamin, Iodine tablets, Sushi/Seaweed, Power/Protein Bars or Boost Drinks.** If yes, please list which and the last time used: _____

In the past year, have you received any IV contrast (ie for CT scan or heart catheterization?). If yes, please list date performed._____

Please circle yes or no to each of the following questions below.

General

Yes No Any hot flashes?

Yes No Any change in appetite?

Yes No Do you have fatigue that prevents you from doing daily activities?

Yes No Any **increase** in weight in the last year (more than 10 lbs)

Yes No Any **decrease** in weight in the last year (more than 10 lbs)

Ears, Nose, Throat

Yes No Do you have any trouble smelling aromas (like coffee)?

Yes No Do you have decreased hearing?

Yes No Has your voice been persistently horse?

Yes No Do you have trouble swallowing?

Eyes

Yes No Do you have any bulging of your eyes?

Yes No Any problems with your peripheral vision?

Yes No Do you have eye pain?

Yes No Do you have double or blurry vision?

Yes No Do you have excessive tearing of your eyes?

Yes No Do you have sensitivity to sunlight?

Lungs

Yes No Do you snore?

Yes No Has your family every said you stop breathing while you sleep?

Yes No Any shortness of breath with lying flat?

Heart

Yes No Do you have leg cramps when walking?

Yes No Do you have chest pressure or tightness when walking or working?

Yes No Do you have any swelling in your legs?

Yes No Does your heart race or thump?

Gastrointestinal

Yes No Do you have constipation?

Yes No Do you have diarrhea?

Yes No Do you have frequent nausea or vomiting?

Endocrine

Yes No Do you feel cold in a room that is comfortable for others?

Yes No Do you feel hot in a room that is comfortable for others?

Yes No Do you experience excessive thirst?

Yes No Do you have excessive urination?

Yes No Have you ever had any broken bones?

Genitourinary

Yes No (men only) Do you have problems obtaining or maintaining an erection?

Yes No (women only) Do you have vaginal dryness?

Yes No Do you have a reduced sex drive?

Yes No Do you have nipple discharge?

Yes No Do you regularly get up more than once from sleeping to urinate?

Yes No Do you have trouble starting urination?

Yes No Have you ever passed a kidney stone?

Musculoskeletal

Yes No Do you have trouble standing from a seated position?

Yes No Do your arms get tired when doing tasks above your head?

Yes No Do you have pains in your joints?

Yes No Do you have pains in your muscles?

Skin

Yes No Do you have increasing numbers of skin tags?

Yes No Do you have excessive perspiration?

Yes No Do you have dark purple stretch marks anywhere on your body?

Yes No Have you experienced any loss of body hair?

Yes No Do you experience dry skin?

Yes No Do you have brittle nails?

Yes No Have you experienced any excessive/abnormal hair growth?

Yes No Have you noticed increased acne?

Yes No Have you noticed any darkening of the color of your skin?

Neurological

Yes No Do you have frequent headaches?

Yes No Have you ever felt faint/lightheaded?

Yes No Do you have numbness, tingling, or pain of the hands or feet?

Yes No Have you ever passed out?

Yes No Do you suffer from any tremors or shaking of your hands?

Hematologic

Yes No Do you notice easy bruising?

Yes No Do you notice any enlarged lymph nodes?

Behavioral

Yes No Do you have any difficulty concentrating?

Yes No Do you suffer from depression?

Yes No Do you have any anxiety?

Yes No Do you have trouble sleeping

Diabetes Questionnaire

Only fill out if you are seeing the Endocrinologist about your Diabetes

To make your first visit run smoothly please bring this paperwork as well as your glucometer and a log of your blood sugars for at least the past 2 weeks if you have Type 1 Diabetes, you are on Insulin, or your last hemoglobin A1C was > 7%.

Do you have Type 1 or Type 2 Diabetes? _____

How old were you when you were first diagnosed with diabetes? _____

Have you ever been hospitalized for uncontrolled blood sugars? _____

If yes, when? _____

Have you developed any of the following complications from your diabetes? (yes or no)

Eye disease (diabetic retinopathy) _____

Kidney disease _____ Protein in your urine _____

Neuropathy _____ Gastroparesis _____

Have you ever had a heart attack? _____ Have you ever had a stroke? _____

Do you check your blood sugar at home? _____

If yes, how often? _____

Do you experience low blood sugars? _____

If yes, how often?_____

What symptoms do you feel when your blood sugar is low? _____

Have you ever been unconscious due to a low blood sugar? _____

Do you have a glucagon pen at home? _____

Have you ever had to use a glucagon injection to treat a low blood sugar? _____

Please give an example of your typical meals:

Breakfast _____

Lunch _____

Dinner _____

Do you snack between meals? _____

If yes, what type of foods? _____

What do you usually drink during the day? (water, soda, juice etc..) _____

Do you exercise? _____

If yes, how often (minutes a week/days a week) _____

What type of exercise? _____

Do you get regular eye exams? _____

If yes, date of last exam:_____

Name of eye doctor:_____

Have you ever been told you have retinopathy (diabetic eye disease)? _____

Have you ever had laser eye surgery? If yes, when? _____

Do you see the dentist on a regular basis? _____

If yes, date of last exam:_____

Name of dentist:_____

Do you see a foot doctor on a regular basis?

If yes, date of last exam:_____

Name of podiatrist:_____

Have you attended Diabetes Education classes?_____

If yes, when and where? _____

Do you wear a medical alert bracelet indicating you have diabetes? _____

Please indicate if you have received the following vaccinations & when they were last given:

Influenza (Flu)_____ Pneumovax (Pneumonia)_____