Medical CONSULTANTS
Patient Focused • Quality Oriented • Physician Driven

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Endocrinology History Form

Name: _____DOB: _____Date: _____
Requesting Practitioner:_____Age:_____

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you:

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain		Irregular menses (female only)	
Recent weight change		Heart skips beats			
Heat or cold intolerance		Heart beats too fast		Nighttime urination	
Head and Neck	**YES**	Calf pain		Frequent urination	
Choking		Feet, ankle swelling		**Gastrointestinal**	**YES**
Difficulty swallowing		**Lungs**	**YES**	Abdominal pain	
Prolonged hoarseness		Cough		Heartburn/Indigestion	
Change in neck size		Sputum		Constipation	
Skin	**YES**	Wheezing		Frequent diarrhea	
Rash, dryness, itching		Shortness of breath		Nausea or vomiting	
Pigment changes		**Musculoskeletal**	**YES**	**Endocrine**	**YES**
Bleeding tendencies		Bone pain		Excessive thirst	
Eyes	**YES**	Arm/leg weakness		Hot flashes	
Double, failing vision		Leg cramps		Changes in body hair	
Dry eyes		Fractures		Poor sex drive	
Neurologic	**YES**	**Ears, Nose, Mouth**	**YES**	Erection problems	
Light headed/dizziness		Nose bleeds		**Psychiatric**	**YES**
Numbness/tingling		Ear ache		Depression	
Frequent headaches		Ringing in ears		Anxiety	
		Sores in mouth		Other	

If you are a Diabetic, please complete the following questions. (If not, please skip to the back page.)

In what year were you diagnosed with diabetes? _____
Have you ever been hospitalized for Diabetic Ketoacidosis (DKA)? _____ How many times? _____
Do you have a home glucose monitor? _____ How old is the monitor? _____ What brand name?_____
How often do you check you blood glucose?_____
What is the typical glucose reading you obtain before?
Breakfast _____ Lunch _____ Dinner _____ Bedtime _____
Have you ever experienced symptoms of low blood sugar? _____ If yes, how often? _____
Do you measure your blood glucose level when you get these symptoms? _____
If yes, at what blood glucose level do you get these symptoms?_____
Have you ever been unconscious because of low sugar? _____
Do you have an emergency glucagon (injection) kit? _____
Has diabetes affected your eyes?_____ Date of last eye appointment? _____ Who did you see?_____
To the best of your knowledge, has diabetes affected your kidneys? _____
Do you experience the following, Tingling in your feet/hands? _____ Diarrhea/vomiting? _____
Weight loss? _____ Lightheadedness?_____
If you are on insulin, where do you give injections? Arms _____ Abdomen_____ Legs _____ Buttocks _____
Have you ever attended diabetes teaching classes? _____ Where and how long ago?_____
Have you ever met with a dietitian? _____ Where and how long ago?_____
How much has your weight changed over the past year?_____
Do you exercise regularly? _____ What type of exercise?_____
(Females only) If you have been pregnant, were you a diabetic during pregnancy?_____
Do you currently use birth control?_____

Please list all of your medications, including over the counter medications. (If you need additional space please bring a list, including dosages, to your appointment) Include Medication Name, Dosage and Number of Times per Day:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list allergies

Medication	Reaction

Past Medical History: Please check if you have or had any of the following:

Ulcerative Colitis or Crohn's Disease		TB	
Colon polyps or Colon Cancer		High Blood Pressure	
Liver Disease		High Cholesterol	
Pancreatic Disease		Diabetes	
Osteoporosis		Thyroid Disease	
Bleeding Disorder		Kidney Disease	
Have you ever had a Blood Transfusion		Seizures	
Lung Disease		Psychiatric Disorder	
Heart Disease		Depression	
Other		Other	

Please list any hospitalizations and surgeries, and an approximate date:

Date	Reason for hospitalization or surgery

Family History: List your immediate family members including brothers, sisters and children and their health status: (Please list on a separate sheet if necessary)

Relative	X if Deceased	Age	Health Problems
Father			
Mother			
Brother/Sister			
Brother/Sister			

Social History:

Marital Status: Single _____ Divorced _____ Married _____ Widow/Widower _____ Other _____
Do you smoke? Yes _____ No _____ If yes, how many packs per day?_____ Number of Years: _____
Did you smoke? Yes _____ No _____ If yes, when did you quit? _____ Number of Years Smoked: _____
Do you drink alcohol? Yes _____ No _____ If yes, How often? _____
What do you drink and how much?_____
Number of children: _____ Place of employment: _____

Patient Signature: _____ Date:_____
Physician Signature: _____ Date:_____