ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name_____ DOB _____ Age _____ Date _____

PAST MEDICAL HISTORY *(Have You Had These?)*

Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Retinopathy
___	___	Arthritis	___	___	Peptic Ulcer
___	___	Pneumonia	___	___	Gall Bladder Disease
___	___	Diabetes	___	___	Bowel Disorder
___	___	Thyroid Disease	___	___	Liver Disease
___	___	High Cholesterol	___	___	Kidney Stones
___	___	Asthma/Emphysema	___	___	Kidney Disease
___	___	Heart Disease	___	___	Stroke
___	___	Bleeding Disorders	___	___	Epilepsy
___	___	Radiation Treatments	___	___	Cataracts
___	___	Tuberculosis	___	___	Gout
___	___	Cancer	___	___	Anemia
___	___	HIV	___	___	Bladder Infections
___	___	Amputations	___	___	Neuropathy
___	___	Pituitary Disease	___	___	Parathyroid Disease

FAMILY MEDICAL IDSTORY *(Have Any Blood Relatives Ever Had?)*

Yes	No		WHO	Yes	No		WHO
___	___	Diabetes	_____	___	___	Cancer	_____
___	___	Thyroid Disease	_____	___	___	Pituitary Disease	_____
___	___	High Blood Pressure	_____	___	___	HIV	_____
___	___	Heart Disease	_____	___	___	Abnormal Bleeding	_____
___	___	Adrenal Disease	_____	___	___	Hepatitis	_____

SOCIAL HISTORY

Married_____ Single _____ Divorced_____ Widowed_____ Separated_____

Have you used tobacco? Yes ___ No ___ # of packs per day_____ For how many years? _____

Have you used alcohol? Yes ___ No ___ How much per day_____ For how many years? _____

Do you use caffeine? Yes ___ No ___ Coffee/day_____ Soda/day _____ Tea/day _____

Do you exercise regularly? Yes ___ No ___ Times/week _____

Are you on a regular diet? Yes ____ No_____

Do you use any illicit drugs or cannabis oil? Yes ____ No_____

DIABETIC PATIENTS ONLY

1. When were you diagnosed with diabetes? _____
2. Have you ever been hospitalized for high blood sugars or DKA? Yes No
3. Do you have frequent low blood sugar reactions? Yes No
   If yes, how often? _____ Daytime or nighttime? _____
4. Do you test your own blood sugar? Yes No times/day_____
   If yes, what meter do you use? _____ What is your blood sugar range? _____
5. Have you had diabetes education? Yes No

ALLERGIES *(Tothefollowing medications, please check all that apply)*

Penicillin _____ Sulfa_____ Aspirin_____ Tetanus _____ Serum _____

Antibiotics _____ *If yes, please name:* _____

Other allergies, *please specify:* _____

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Date_____ DOB_____ Age_____ Patient Name_____

PREVIOUS SURGICAL PROCEDURES

			Approx. Date
Tonsillectomy	Yes____	No ____	_____
Appendectomy	Yes____	No ____	_____
Hysterectomy	Yes____	No ____	_____
Cholecystectomy *(removal of Gall Bladder)*	Yes____	No ____	_____
Other	Yes____	No ____	_____

REVIEW OF SYSTEMS *(In Last Six Months)*

SKIN

Dry	Yes____	No ____
Moist	Yes____	No ____
Rash	Yes____	No ____
Normal	Yes____	No ____
Open wounds	Yes____	No ____
Excessive Bruising	Yes____	No ____

CARDIAC/ RESPIRATORY

Shortness of breath	Yes____	No ____
Chest pain	Yes____	No ____
Heart palpitations	Yes____	No ____
Persistent cough	Yes____	No ____

GASTROINTESTINAL

Ulcers	Yes____	No ____
Liver disease	Yes____	No ____
Diarrhea	Yes____	No ____
Constipation	Yes____	No ____
Blood in stool	Yes____	No ____

KIDNEYS

Stones	Yes____	No ____
Kidney infection	Yes____	No ____
Bladder infection	Yes____	No ____
Blood in urine	Yes____	No ____

NEUROLOGICAL

Severe headaches	Yes____	No ____
Confusion	Yes____	No ____
Tingling	Yes____	No ____
Numbness	Yes____	No ____

ENDO

Excessive thirst	Yes____	No ____
Increased urination	Yes____	No ____
Rising to void, *(more than once a night)*	Yes____	No ____

General Review

Weight change	Yes____	No ____
Extreme fatigue	Yes____	No ____
Fainting	Yes____	No ____
Dizziness	Yes____	No ____
Impaired sight	Yes____	No ____
Nose bleeds	Yes____	No ____
Anxiety	Yes____	No ____

Female Reproductive

Age of Menstruation	_____
Is it regular?	_____
No. of pregnancies	_____
No. of children born alive	_____
Breast discharge	_____
Date of last menstrual period?	_____
Date last mammogram?	_____

Male Reproductive

Prostate disorder?	Yes____	No ____
Testicular mass?	Yes____	No ____
Impotence?	Yes____	No ____

THYROID

Has voice changed?	Yes____	No ____
Difficulty swallowing?	Yes____	No ____
Nodule/growth of thyroid?	Yes____	No ____
Painful thyroid?	Yes____	No ____
Goiter problem?	Yes____	No ____
Hair - Coarse	Yes____	No ____
- Normal	Yes____	No ____
- Thin	Yes____	No ____
- Loss of	Yes____	No ____

Vaccination

Covid-19	Yes____	No ____
Tetanus Vaccine *(last 10 years)*	Yes____	No ____

IMAGING *(in the past six months)*

Thyroid ultrasound	Yes____	No ____	MRI of pituitary	Yes____	No ____
Thyroid uptake & scan	Yes____	No ____	CTscan of pituitary	Yes____	No ____
Whole body scan	Yes____	No ____	MRI/CT adrenal	Yes____	No ____
Parathyroid scan	Yes____	No ____	Dexa scan	Yes____	No ____