Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Consult requested by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other physicians: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy name/location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Personal & Family Medical History** | **I** have this. \*\*\*Please include year diagnosed | A **family member** has this. \*Please note relationship |  | **I** have this. \*\*\*Please include year diagnosed | A **family membe**r has this. \*Please note relationship |
| Diabetes   * Type 1 * Type 2 |  |  | High prolactin levels |  |  |
| Complications from Diabetes   * Eye problems * Kidney problems * Nerve problems |  |  | Low testosterone |  |  |
|  |  | Adrenal nodules |  |  |
|  |  | Adrenal insufficiency (low cortisol) |  |  |
| High blood pressure |  |  | Prescribed steroids |  |  |
| High cholesterol |  |  | Last menstrual period   * # of pregnancies * # of births |  |  |
| Prior heart disease?  Prior heart attack?  Prior heart surgery or stents?  Prior stroke or TIA?  Irregular heartbeat? |  |  | Polycystic ovarian syndrome (PCOS) |  |  |
|  |  | Vision problems |  |  |
|  |  | Frequent headaches |  |  |
|  |  | Seizures |  |  |
| Hypothyroidism (low thyroid) |  |  | Sleep apnea |  |  |
| Hyperthyroidism (high thyroid) |  |  | Heartburn/reflux |  |  |
| Thyroid nodules   * Prior biopsy? |  |  | Depression/anxiety |  |  |
| Osteoporosis |  |  | Colitis/Crohn/celiac disease |  |  |
| Parathyroid disease |  |  | Arthritis |  |  |
| Kidney stones |  |  | Blood clots in lungs or legs |  |  |
| Pituitary tumor |  |  | Hepatitis/liver problems |  |  |
| Other: |  |  | Lupus |  |  |
| Emphysema/COPD |  |  |
| Cancer   * Please specify type |  |  |

|  |  |
| --- | --- |
| **Surgeries** | Please list year |
|  |  |
|  |  |
|  |  |
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|  |  |  |
| --- | --- | --- |
| **Medication Name** | Dose | How many times per day? |
|  |  |  |
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**Allergies**

Any allergies to medications? Yes No \*Please list medication and reaction

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Marital status: Single Married Domestic partnership Divorced Widowed

Do you have children? Yes No Number of children: \_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education completed: High school Some college College degree Graduate degree Other

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you exercise? Yes No How many times per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes No

If Yes, how many packs each day?\_\_\_\_\_\_\_\_\_\_\_ When did you start smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If No, have you ever smoked? Yes No When did you quit smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? Yes No How many per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use recreational drugs? Yes No Which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations**

Are your immunizations up to date? Yes No

When was your last flu vaccine? This year Last year >1 year ago Never

When was your last pneumonia vaccine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which pneumonia vaccines have you received? Prevnar (PCV-13) Pneumovax (PCV-23)

**Please circle any symptoms you have noticed in the last year**

**Constitutional**

Fever

Weight loss

Weight gain

Fatigue

**Eyes**

Vision changes

Eye pain

Eye dryness

**Ears, Nose, Mouth, Throat**

Hearing loss

Ear pain

Ear discharge

Nasal drainage

Sinus pressure

Sore throat/Hoarseness

Snoring

Difficulty swallowing

**Cardiovascular**

Chest pain

Shortness of breath during exertion

Palpitations

Leg Swelling

**Respiratory**

Shortness of breath

Cough

Wheezing

Sleep apnea

**Gastrointestinal**

Nausea

Vomiting

Diarrhea

Constipation

Heartburn

Change in appetite

Office Use Only

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BP: \_\_\_\_\_/\_\_\_\_\_\_

BMI: \_\_\_\_\_\_ HR: \_\_\_\_\_\_ SpO2: \_\_\_\_\_\_ RR: \_\_\_\_\_\_\_

**Genitourinary**

Painful urination

Frequent urination

Vaginal discharge

Difficulty emptying bladder

Irregular Cycles

Getting up at night to urinate

Erection problems

Decreased libido

**Musculoskeletal**

Joint swelling

Back pain

Muscle pains

Muscle weakness

**Integumentary**

Rash

Dry skin

Change in skin pigment

**Neurological**

Headaches

Weakness

Numbness in hands/feet

Dizziness

Memory loss/Problems concentrating

**Psychiatric**

Depression

Anxiety

Insomnia

**Metabolic**

Excessive thirst

Excessive urination

Cold intolerance

Heat intolerance

Unwanted hair growth

Hair loss

**Hematologic**

Swollen lymph nodes

Easy bruising

Easy bleeding

**Immunologic**

Seasonal allergies

Food allergies

Itching

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| If you have **Diabetes**, please answer the following: | | | | | | |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| Do you check blood sugar at home?   * How often? |  |  |  | Have you taken Diabetes Education classes? |  |  |
| When was your last eye exam? |  |  |  | Do you follow a diabetic diet? |  |  |
| What **diabetes** medications have you used before, but are not currently taking? |  |  |  | Do you have any recurrent infections or slow healing wounds? |  |  |
| Any other problems related to your diabetes? |  |  |  | Do you have a personal or family history of pancreatitis, multiple endocrine neoplasia or medullary thyroid cancer? |  |  |
| Do you have frequent bladder infections? |  |  |  | Do you have frequent yeast infections? |  |  |
|  | | | | | | |
| If you have **Thyroid** problems, please answer the following: | | | | | | |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| Have you had radiation treatments to your neck?? |  |  |  | Do you have any pain or swelling in the front of your neck? |  |  |
| Do your eyes bulge? |  |  |  | Do you have any problems swallowing? |  |  |
| Do you have any double vision? |  |  |  | Are you hotter or colder than others around you? |  |  |
|  | | | | | | |
| If you have **Osteoporosis, Osteopenia,** or **Parathyroid** problems, please answer the following: | | | | | | |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| Have you broken any bones? Which ones? |  |  |  | Do you eat milk/cheese/yogurt daily? |  |  |
| Have you fallen in the last year? How many times? |  |  |  | When was your last bone density test? |  |  |
| What was your height as a young adult? |  |  |  | Do you have problems getting out of a chair? |  |  |
| Do you take calcium or vitamin D? How much? |  |  |  | Do you use antacids frequently? |  |  |
| Do you have bone pain? |  |  |  | Do you have abdominal pain? |  |  |
| Do you need any major dental work (other than routine cleaning)? |  |  |  | Did either of your parents have a broken hip? |  |  |
| Are you taking steroids now? Or previously took for 3+ months? |  |  |  |  |  |  |
|  | | | | | | |
| If you have **Adrenal** problems, please answer the following: | | | | | | |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| Do you have spells with headache, racing heart, and seating ALL at the same time? |  |  |  | Do you have problems getting out of a chair? |  |  |
| Do you ever have a low potassium? |  |  |  | Do you have any purple stretch marks? |  |  |
| Have you taken steroid medication recently? |  |  |  | Do you have hard to control blood pressure or diabetes? |  |  |
|  | | | | | | |
| If you have **Another** endocrine problem (pituitary, hormone replacement), please answer the following: | | | | | | |
|  | **Yes** | **No** |  |  | **Yes** | **No** |
| Is your voice deeper than it used to be? |  |  |  | Do have leakage from your nipples? |  |  |
| Is your nose wider than it used to be? |  |  |  | Do you have increased acne? |  |  |
| Are your hands or feet bigger than they used to be? |  |  |  | Do you have vaginal dryness? |  |  |
| Do you have any problems with peripheral vision? |  |  |  | Do have painful intercourse? |  |  |
| Do you have night sweats? |  |  |  | Are you able to reach orgasm? |  |  |
| Do you have hot flashes? |  |  |  | Do you have sleep apnea? |  |  |
| Has it been more than 6 months since your last period? |  |  |  | Any problems conceiving pregnancy? |  |  |
| You have more than 4 weeks between periods? |  |  |  |  |  |  |
|  | | | | | | |
| Any other problems you wish to discuss? | | | | | | |
| Clinician Notes: | | | | | | |



