Florida Medical Clinic
Your life. Our specialty.

ENDOCRINOLOGY

PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

Name of the Person Completing this form: _____

If Not the Patient, Relationship to Patient: _____

Reason for your visit to Endocrinologist: _____

Have you seen an Endocrinologist in the past, if so for what and when: _____

_____

PAST HISTORY (Personal)

Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Kidney Stones	☐	☐	Foot/Leg Ulcers	☐	☐
Alcohol Overuse	☐	☐	Low or High Calcium	☐	☐	Kidney Disease	☐	☐
Prolonged use of Steroids	☐	☐	Carpal Tunnel	☐	☐	Bypass Surgery	☐	☐
Arthritis	☐	☐	Adrenal Tumors	☐	☐	Low Blood Sugar	☐	☐
Asthma	☐	☐	Infertility	☐	☐	Neck Masses/Lumps	☐	☐
Cancer	☐	☐	Laser Eye Treatments	☐	☐	Osteoporosis	☐	☐
Sleep Apnea	☐	☐	Brain/Pituitary Tumors	☐	☐	Low Vitamin D	☐	☐
Stroke	☐	☐	High Cholesterol	☐	☐	Nervous Breakdown	☐	☐
Intraabdominal Bleeding	☐	☐	Heart Attack	☐	☐	Thyroid Cancer	☐	☐
Low or High Potassium	☐	☐	Other Heart Disease	☐	☐	Stomach Ulcers	☐	☐
Diabetes	☐	☐	Hepatitis	☐	☐	Thyroid Disease	☐	☐
Emphysema	☐	☐	High Blood Pressure	☐	☐	Others Not Listed Above _____		

_____

_____

SOCIAL HISTORY

Never Married ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( )

OBSTETRIC HISTORY

How many pregnancies have you had? _____
How many premature births have you had? _____
How many miscarriages/abortions have you had? _____
How many living children do you have? _____
Grandchildren? _____
Great Grandchildren? _____

When was you last menstrual period? (date if still having periods; age if past menopause) _____
If still having menstrual periods: Age of menarche: _____
Regularity of menstruation: _____

PERSONAL HABITS

1. Have you ever smoked? ☐ Yes ☐ No Have you used chewing tobacco? ☐ Yes ☐ No # of years _____
   Are you a regular smoker now? ☐ Yes ☐ No If no, when did you quit? _____
   Number of cigarettes per day _____ ☐ Cigars ☐ Pipe How many years have you or did you smoke? _____

2. Check if you regularly drink:
   Hard liquor, 1-3 oz. per day ☐ Over 3 oz. per day ☐ Beer- 1 bottle per day ☐ Beer- 2 bottles per day ☐
   Beer- 3 bottles or more per day ☐ Wine – 1 glass per day ☐ Wine – 2 glasses per day ☐ Wine- 3 or more glasses per day ☐

3. Have you ever used any of the following? Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other _____

OPERATIONS List and indicate approximate year.

_____
_____
_____
_____

SERIOUS INJURIES (Other than the above) List injuries and give approximate dates.

_____
_____
_____

HOSPITALIZATIONS: (other than operations)
List reasons and approximate dates.

_____
_____
_____
_____
_____
_____
_____
_____

RECENT ER or URGENT CARE VISITS: List approximate dates and reasons.

_____
_____
_____
_____
_____

RADIATION TREATMENTS: _____
_____

FAMILY HISTORY	Circle Sex	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE OF DEATH	CAUSE
Father					
Mother					
Brothers/Sisters	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Sons/Daughters	M F				
	M F				
	M F				
	M F				
	M F				

REVIEW OF SYSTEMS

Have you experienced any of these symptoms in the last 3 months on a consistent basis, more than 2-3 times per week? Check all YES answers and leave all NO answers blank, if you are not sure make a "?".

SKIN
___ Rash
___ Pigmented marks
___ Skin tags
___ Increased sweating
___ Oily skin
___ Lump or growth
___ Feet/leg ulcers
___ Swollen lymph nodes
___ Changes in skin color
___ Face pallor/plethora/flushing
___ Purple stretch marks

EYES
___ Glasses
___ Glaucoma
___ Change in vision (double/blurred)
___ Pain in eyes
___ Halo around lights
___ Conjunctivitis

NOSE AND THROAT
___ Hoarseness
___ Nose bleed
___ Sinus problems
___ Runny nose
___ Sores in mouth
___ Poor dentition
___ Changes in voice
___ Tightness in neck

BREAST
___ Lump
___ Discharge
___ Pain

MUSCULOSKELETAL
___ Broken bones
___ Back pain
___ Painful joints
___ Sore muscles
___ Muscle weakness

DIGESTIVE
___ Loss of appetite
___ Nausea/vomiting after eating
___ Vomiting blood
___ Passing blood in bowels
___ Diarrhea
___ Constipation
___ Black Stools
___ Jaundice
___ Frequent heartburn
___ Frequent nausea/vomiting
___ Difficulty swallowing
___ Stomach pain
___ Stomach ulcers
___ Hemorrhoids

GENITOURINARY
___ Difficulty starting urine stream
___ Painful urination
___ Blood in urine
___ Discharge (penile/vaginal)
___ Blood or pus in urine
___ Unexpected vaginal bleeding after menopause
___ Difficulty controlling urine
___ Erectile dysfunction

ENDOCRINE
___ Frequent urination
___ Unusual thirst
___ Tremors
___ Nipple secretion
___ Decreased libido
___ Heat or cold intolerance
___ Hair changes
___ Change in ring size
___ Change in shoe size
___ Breast enlargement (males)

NEUROLOGIC
___ Convulsions/epilepsy
___ Migraines
___ Frequent headaches
___ Fainting
___ Lightheadedness
___ Dizziness
___ Insomnia
___ Depressed
___ Stroke/paralysis
___ More nervous than average person
___ Difficulty sleeping most nights
___ Decreased hearing or smell

GENERAL
___ Fever
___ Unusual fatigue
___ Unusual weakness
___ Easy bruising
___ Night sweats
___ Anemia
___ Cancer
___ Weight loss
___ Weight gain

HEART AND LUNG
___ Chest pain
___ Shortness of breath
___ Blood in sputum
___ Cough
___ Palpitations
___ Wheezing
___ Unusual heart beat
___ Heart attack
___ Swollen ankles
___ Murmur
___ Rheumatic fever
___ Pneumonia
___ Emphysema

MEDICATIONS:

List each drug, including insulin, its amount, and how often you take it.

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list medications and the reaction you had to them:

PLEASE BRING ALL MEDICATIONS YOU ARE TAKING TO EVERY VISIT!

OTHER PATIENT COMMENTS: _____

DO NOT WRITE BELOW THIS LINE

PHYSICIAN COMMENTS: _____

PHYSICIAN SIGNATURE

OLD RECORDS REQUESTED: ☐ NO ☐ YES

DOCTOR NAME: _____ HOSPITAL NAME: _____

ST. ADDRESS: _____ ST. ADDRESS: _____

CITY,ST,ZIP: _____ CITY,ST,ZIP: _____