Tampa General Medical Group

Name: _____[Type text] Date: _____
Date of Birth: _____

ENDOCRINOLOGY HEALTH HISTORY

What is the reason for your visit? _____

MEDICATIONS List current prescription and over-the-counter medications. Also list current vitamin, herbal, and nutritional supplements:

MEDICATION/SUPPLEMENT	DOSE	HOW MANY TIMES PER DAY?

☐ Check here if list of medications continues on the back of this paper.
☐ Check here if list is attached.

ALLERGIES List any allergies to medications: _____

PHARMACY NAME/ADDRESS/PHONE NUMBER: _____

_____

PAST MEDICAL HISTORY Mark **(×)** all that apply.

□ Acid reflux disease
□ Chemical dependency
□ High cholesterol/high triglycerides
□ Pneumonia
□ Alcoholism
□ Depression
□ HIV/AIDS
□ Polio
□ Anemia
□ Diabetes
□ Irregular menstrual periods
□ Prostate problem
□ Anorexia
□ Emphysema
□ Kidney disease
□ Psychiatric care
□ Arthritis
□ Epilepsy/seizures
□ Liver disease
□ Stroke
□ Asthma/lung problem
□ Emphysema/COPD
□ Glaucoma
□ Migraine headaches
□ Suicide attempt
□ Bleeding disorders
□ Goiter
□ Miscarriage
□ Thyroid problems
□ Breast lump
□ Gout
□ Multiple sclerosis
□ Tuberculosis
□ Bulimia
□ Heart disease
□ Mumps
□ Ulcers
□ Cancer
□ Hepatitis/liver problems
□ Osteoporosis
□ Osteopenia
□ Broken bones
□ Vaginal infections
□ Cataracts
□ High blood pressure
□ Pacemaker

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☐ Check here if list of Past Medical History continues on the back or separate paper is attached.

SURGICAL/HOSPITALIZATIONS HISTORY

List past surgeries/hospitalizations and years.

Surgery/ Hospitalization	Year

☐ Check here if list continues on back or separate paper with list is attached.

FAMILY HISTORY

Complete health information about your family.

RELATION	AGE	AGE at DEATH	CAUSE of DEATH	MEDICAL CONDITION LISTED BELOW? (YES or NO)
Father				
Mother				
Brothers				
Sisters				

Check the diagnoses below if any of your blood relatives has or had these conditions.
If so, please state the person's relationship to you:

CONDITION	Which of your above relatives has or had this?
□ Diabetes	
□ Thyroid disease	
□ High blood pressure	
□ Heart disease	
□ Stroke	
□ Breast cancer	
□ Ovarian cancer	
□ Prostate cancer	
□ Kidney stones	
□ Osteoporosis	
□ High cholesterol	

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IMMUNIZATIONS:

When was your last pneumonia vaccine? _____ □ Never had
When was your last flu vaccine? _____ □ Never had

SOCIAL HISTORY Mark **(×)** all that apply.
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Living Situation: □ Alone □ Partner □ Parents □ Children (# of children ____) □ Nursing Facility
Occupation: Job Title_____ □ Retired □ Unemployed
□ Student
Exercise: Type of exercise _____ How often in one week: _____
Do you smoke? ☐ Yes ☐ No ☐ Never
If yes, how much? _____
Do you drink Alcohol? ☐ Yes ☐ No
If yes, about how much? _____
Recreational drugs used:_____
Hobbies/relaxation: _____

FOR WOMEN ONLY:
How old were you when you had your first menstrual cycle? _____
Are your cycles regular? ☐ Yes ☐ No
Date of the beginning of your last menstrual cycle _____
How many times have you been pregnant? _____
Did you have difficulty getting pregnant? _____
How many children have you had? _____ How many miscarriages? _____

FOR DIABETES PATIENTS ONLY:
What year were you diagnosed with diabetes? _____
How old were you when diagnosed? _____
Have you ever been hospitalized for high blood sugars? When and where?
_____
_____
_____
When was your last eye exam? _____
If on insulin therapy, how long have you been on insulin? _____
Can you feel when your blood sugar is low? _____
Have you ever required the assistance of others to raise your blood sugars after a low blood sugar episode? If so, please describe:
_____
_____

How often do you check your blood sugars at home_____
If you have an insulin pump, what pump is it? _____
How long have you been on an insulin pump? _____

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If known, please report:
Insulin to carbohydrate ratio: _____ **Blood sugar goal: _____**
Sensitivity: _____ **Please document your pump's current basal**
Insulin active time: _____ **settings on the back of this paper.**

During the past month, what have your blood sugars been:

	HIGHEST	LOWEST	AVERAGE
Pre-breakfast (fasting)			
Pre-lunch			
Pre- dinner			
Bedtime			

****PLEASE ENSURE THAT YOU BRING YOUR LOGBOOK AND GLUCOMETER TO YOUR APPOINTMENT.****

REVIEW OF SYSTEMS
SYMPTOMS Mark **(×)** symptoms that pertain to you.

GENERAL: ☐ Fever ☐ Chills ☐ Sweats ☐ Weight gain ☐ Weight loss ☐ Loss of appetite
☐ Excessively tired ☐ Heat or cold intolerance
SKIN/HAIR/NAILS: ☐ Skin rash ☐ Dry skin ☐ Change in hair or nails ☐ Poor wound healing
☐ Excessive perspiration ☐ Itching
EYES: ☐ Eye pain ☐ Vision blurring ☐ Double vision ☐ Vision loss ☐ Eye redness ☐ Eye infection
EARS/NOSE/ MOUTH/THROAT: ☐ Ringing/buzzing in ears ☐ Loss of hearing ☐ Ear pain
☐ Nasal congestion ☐ Loss/lack of smell ☐ Frequent nose bleeds ☐ Hoarseness ☐ Sore throat
☐ Difficulty swallowing ☐ Swelling
CARDIOVASCULAR: ☐ Chest pain/pressure ☐ Irregular heart beat ☐ Loss of consciousness
☐ Swelling of hands/feet ☐ Shortness of breath ☐ Palpitations ☐ Leg cramps when walking
GASTROINTESTINAL: ☐ Vomiting ☐ Nausea ☐ Diarrhea ☐ Constipation ☐ Change in bowel habits
☐ Stomach pain ☐ Indigestion/Heart burn ☐ Rectal bleeding/bloody stools
RESPIRATORY: ☐ Cough ☐ Shortness of breath ☐ Snoring ☐ Coughing up mucous
☐ Coughing up blood ☐ Wheezing
GENITO-URINARY: ☐ Painful urination ☐ Poor bladder control ☐ Blood in urine ☐ Frequent urination
☐ Difficulty urinating ☐ Decreased sex drive
WOMEN ONLY: ☐ Vaginal discharge ☐ Absent menstrual period ☐ Irregular menstrual period
☐Breast lump/discharge ☐ Menstrual pain/cramps
MEN ONLY: ☐ Erection difficulties ☐Testicular lump/pain ☐Penile discharge
MUSCULOSKELETAL: ☐ Back pain ☐ Joint pain ☐ Muscle cramps ☐ Muscle weakness ☐ Arthritis
☐ Stiffness of the joints
NEUROLOGIC: ☐ Memory loss ☐ Seizures ☐ Dizziness ☐ Temporary paralysis ☐ Tremors
☐ Loss of Consciousness ☐ Numbness/Tingling ☐ Headache
PSYCHIATRIC: ☐ Depression ☐ Anxiety ☐ Paranoia ☐ Suicidal thoughts ☐ Hallucinations
ENDOCRINE: ☐ Cold intolerance ☐ Heat intolerance ☐ Frequent thirst ☐ Increased hunger

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☐ Increased urination ☐ Weight loss or gain

HEME/LYMPHATIC: ☐ Slow wound healing ☐ Abnormal bruising ☐ Bleeding difficulties

☐ Enlarged lymph nodes

ALLERGIC/IMMUNOLOGIC: ☐ Skin conditions ☐ Hay fever ☐ Persistent infections ☐ HIV exposure