ENDOCRINE SPECIALISTS
of Atlanta

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MEDICAL HISTORY QUESTIONNAIRE

Date __________ Patient name ______________________________ Age ______

Date of Birth ______________ Referring physician ______________________________

MEDICATIONS: List all your medications, including over the counter, vitamins, food supplements.
(If there is not enough room, please use the available space on the 2nd page.)

NAME OF DRUG	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

LIST YOUR DRUG ALLERGIES WITH SYMPTOMS YOU EXPERIENCED:

____
____
____
____

LIST ALL HOSPITALIZATIONS, SURGERIES, ACCIDENTS/INJURIES: (If there is not enough room, please use the available space on the 2nd page)

DATE	DIAGNOSIS	LOCATION

975 Johnson Ferry Road, Suite 400,
Atlanta, GA 30342
Phone: (404) 843-4000 • Fax: (404) 250-6701

Social History

Place of birth ___

Marital Status (duration and number of marriages if applicable) ___

Number of children and ages ___

Highest level of education completed and degree ___

Occupations ___

Hazardous exposures at work or at home ___

Pets and other animals exposed to ___

Travel outside U.S. in past 5 years ___

Tobacco usage (current or past) ___ Amount/Duration ___ If applicable, date of cessation ___

Caffeine usage ___ How much per day ___

Alcohol usage ___ How much per week ___

Recreational drug usage ___ Which type and how much per week ___

Exercise: How many times per week ___ Type of exercise ___ How many minutes ___

Family History

Do any of your close relatives have the following conditions:

	Yes	No	Relatives
Heart disease			
High blood pressure			
Stroke			
High Cholesterol			
Diabetes			
Thyroid disease			
Kidney stones			
Osteoporosis			
Mental illness			
Bleeding disorder			
Anemia			
Colon cancer			
Ovarian cancer			
Breast cancer			
Prostate cancer			
Alcoholism			

Immunizations
(in past 10 years)
(Put Date of the Last Shot)

Measles/MMR ___

Tetanus/DPT/DT ___

Hepatitis ___

Flu ___

Pneumonia ___

Other ___

List the following information on your immediate family:

Family member	Age	If not living, age at death	Cause of death
Father			
Mother			
Brother(s)/Sister(s)			

___

___

___

___

REVIEW OF SYSTEMS

Please circle any of the following symptoms which you have experienced in the last two weeks.

SYMPTOM

General

Fever
Fatigue
Weight change >10lbs.
Difficulty Sleeping
Mumps
Measles
HIV infection
Blood transfusion
Breast implants
Alcoholism
Chills
Sweats
Appetite Change
Anemia
Excessive daytime sleepiness

Pulmonary

Cough
Coughing up blood
Coughing up mucous
Bronchitis
Pneumonia
Pleurisy
Wheezing
Asthma
Positive TB skin test
Tuberculosis
Previous chest x ray _____________(date)

Musculoskeletal

Pain in muscles/joints
Join swelling
Muscle cramps
Arthritis
Joint stiffness
Back pain
Handicapped
Gout
Previous bone density _____________(date)

SYMPTOM

Eyes, Ears, Nose, Throat

Sinusitis
Change in vision
Color blindness
Night blindness
Blurred vision
Double vision
Peripheral vision change
Ear pain
Difficulty hearing
Noises in ears
Previous eye exam _____________(date)
Previous dental exam _____________(date)
Hayfever/Allergies
Dizziness/Vertigo
Snoring

Cardiovascular

Palpitations
High blood pressure
Chest pain
Heart disease
Heart murmur
Mitral valve prolapse
Shortness of breath
Swelling
Blue fingers or toes
Phlebitis/blood clots
Leg pain with walking
Previous EKG _____________(date)
Previous treadmill test _____________(date)
Rheumatic Fever
Pacemaker
Passing out

Reproductive (male)

Penile discharge
Penile pain
Lumps in testicles
Painful testicles
Large prostate
Prostatitis
Prostate cancer
Impotence
Cannot have erections
Lack of sexual desire
Cannot have orgasms
Sexually transmitted diseases
Hernia
Last PSA _____________(date) and level _____________

SYMPTOM

Skin

Color/texture change
change in hair or nails
Rashes
Itching
Easily bruised
Hives
Frequent skin infections
Eczema
Psoriasis
Skin Cancer

Urinary

Excessive urination
Urination at night
Pain with urination
Urge to urinate
Urinary tract infection
Kidney stones
Leakage of urine
Change in urine stream
Trouble starting stream
Blood in urine
Brown urine

Neurological

Weakness
Stroke
Paralysis
Difficulty speaking
Seizures
Headaches
Change in sensation
Numbness, tingling
Feeling Faint
Change in handwriting
Tremor
Anxiety
Phobias
Hallucinations
Depression
Psychiatric treatment
Suicide attempt
Thoughts of suicide
Physical/Sexual abuse
Memory Loss

Gastrointestinal

Food intolerance
Problems with teeth/gums
Abnormal taste
Sore tongue
Trouble swallowing
Heartburn
Stomach pain
Excessive belching
Bloating
Nausea
Vomiting
Vomiting blood
Ulcers
Hepatitis/Jaundice
Gallbladder disease
Hemorrhoids
Pancreatitis
Inflammatory Bowel
Spastic colon
Change in stool
Black stool
Blood in stool
Diarrhea
Constipation
Excessive gas
Lactose intolerance
Reflux
Hiatal Hernia
Previous colonoscopy/sigmoidosopy _____________(date)

Endocrine

Ring size change
Shoe size change
Abnormal sweating
Change in appetite
Breast milk
Head/neck irradiation
Thyroid disease
Goiter/enlarge thyroid
Cold intolerance
Heat intolerance
Trouble losing weight
Excessive hair growth
Loss of hair
Acne
Breast enlargement
Excessive hunger
Excessive thirst
Excessive urination
Sugar in the urine
Diabetes
High blood calcium
Low blood calcium
Osteoporosis
Gestational Diabetes

Reproductive (female)

Age you first started your period _________________
Date of your last menstrual period _________________
How many pregnancies have you had? (Including unsuccessful and successful pregnancies) _________________
Weight(s) of newborns? _________________
How many pregnancies went to term? _________________
How many pregnancies were premature? _________________
How many miscarriages/abortions have you had? _________________
Any complications with any pregnancy? ____
Date of hysterectomy____ Were your ovaries also removed? ____________________
Last Pap test ____ Last Mammogram ________________________________

(Circle any of the following, which are chronic or recurrent problems)

Change in periods
Hot flashes/flushes
Sweats
Vaginal dryness
Vaginal infections
PMS
Pain with intercourse

Infertility
Change in sexual desire
Sexually transmitted disease
Breast lumps
Breast pain
Breast discharge
Breast cancer

Wetting of pants