Patient Health History Sheet

FLORIDA DIABETES THYROID & ENDOCRINE CENTER

Please complete and bring in during first visit

Appointment Date:______________________ (For office use only) Acct#:__________

Name:____

Age:________ Date of Birth:______________ Marital Status:______________

Employer:______________________ Occupation:______________________

Full time__________ Part time__________ Preferred Language:______________

Referred by:______________________ Family Dr.:______________________

Referral Dr. Address:______________________ Family Dr. Address:______________________

______________________ ______________________

Referral Dr. Phone: Family Dr. Phone:

Allergies

Allergic to any medications: List: Allergic to seafood		Allergic to foods Allergic to iodine
Seasonal allergies		Had a reaction to iodine or IV contrast

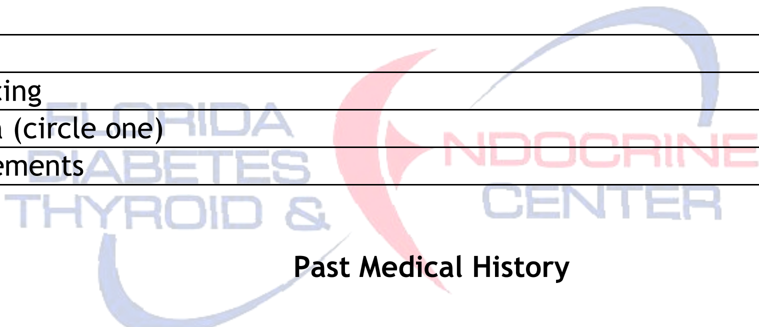
Medication

Preferred Pharmacy: ______________________ Location/Phone: ______________________

Name of Medication	Dosage	Administering Instructions

History of Present Illness

Have you recently experienced:	Yes	No
Unexplained weight gain/loss		
Dizziness/lightheadedness (circle one)		
Syncope/blackout		
Feel hot/cold most of time (circle one)		
Unusual hunger/thirst		
Blurry/decreased/loss of vision		
Dry skin/swelling/coarsening of hair		
Salt craving		
Increased urination/nocturnal urination		
Increased hair growth/loss of hair growth (circle one) if so where: ____________________		
Excessive sweating/night sweats		
Recent difficulty fitting into shoes, wearing rings, gloves that use to fit		
Facial swelling/enlargement		
Erectile dysfunction/decreased libido (circle one)		
Neck swelling/enlargement		
Difficulty swallowing		
Hoarseness of voice		
Palpitations/heart racing		
Constipation/Diarrhea (circle one)		
Increase in bowl movements		



Past Medical History

Diabetes? Y or N ; If yes how long?		Congestive heart failure/fluid in lungs	
Hypoglycemic episodes		Coronary Artery Disease	
Thyroid irradiation		Depression	
Hyperthyroidism		Anxiety	
Hypothyroidism		GERD / Acid indigestion	
Thyroid Nodule		Colitis	
Hyperlipidemia/Dyslipidemia		Hiatal Hernia	
Adrenal mass/dysfunction		Liver Disease/Cirrhosis	
Hypertension		Gallstones	
Anemia		Emphysema/COPD	
Pituitary mass		Pulmonary Fibrosis	
Arthritis		Neck artery murmur	
Osteoporosis		Parkinson's disease	
Gout		Seizures	
Hirsutism (abnormal hair growth)		Stomach ulcer or bleeding ulcer	
Hypogonadism		Stroke	
Menstrual problems		Kidney disease	
Erectile Dysfunction		Renal Failure? Y/N ; Dialysis type:	
Cancer? Y/N ; Type:			

Past Surgical History

Heart valve replacement		Hip replacement	
Appendectomy		Lung surgery	
Breast surgery		Knee replacement	
Carotid Artery surgery (neck)		Thyroid surgery	
Eye surgery		Prostate surgery (TURP)	
Gallbladder removal		Bowel surgery	
Hemorrhoid surgery		Hysterectomy	
		AV Fistulas	
Other:		Other:	

Family History

	Age	Illnesses	Cause of Death
Father			
Mother			
Children			
Grandparents			

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Social History

Do you smoke? Y or N (circle) If yes, how much: ___	Are you single, married, divorced? (circle one)
Do you drink alcohol? Y or N (circle) If yes, how much:______	Do you have children? Y or N (circle) If yes, how many?_____
Do you use any other drugs?	
Do you exercise? Y or N	
Do you diet? Y or N (circle)	

Review of Systems

Please circle Y or N if you are currently experiencing or have recently experienced any of the following symptoms			
Eyes		**Respiratory**	
Wear glasses	Y or N	Wheezing	Y or N
Blurry vision	Y or N	Shortness of breath during sleep	Y or N
Eyesight worsening	Y or N	Shortness of breath during exertion	Y or N
Double Vision	Y or N	Cough without sputum	Y or N
Loss of vision	Y or N	Cough with blood	Y or N
Eye pain	Y or N	Pain on inspiration	Y or N
Eye bulging	Y or N	Chronic cough	Y or N
Watery eyes	Y or N	**Gastrointestinal**	
Eyes don't form tears	Y or N	Increased hunger/eating more than normal	Y or N
Eye surgery/Laser (retinopathy)	Y or N	Difficulty swallowing	Y or N
Ears		Pain on swallowing	Y or N
Hearing loss	Y or N	Heartburn	Y or N
Ringing in the ears	Y or N	Increased thirst	Y or N
Motion sickness	Y or N	Vomiting/Nausea	Y or N
Lightheadedness	Y or N	Diarrhea	Y or N
Neck		Increase in frequency of bowel movements	Y or N
Neck pain/tenderness	Y or N	Constipation	Y or N
Neck lump/swelling	Y or N	Black or bloody stools	Y or N
Thyroid enlargement/Nodule	Y or N	Abdominal pain radiating to back	Y or N
Throat		**Urinary**	
Hoarse voice	Y or N	Increased urination during the day	Y or N
Enlarged tonsils	Y or N	Get up at night to urinate	Y or N
Difficulty swallowing	Y or N	Blood in urine	Y or N
Nose		Increasingly frothy urine	Y or N
Loss of smell	Y or N	**Hematologic**	
Nose bleeds	Y or N	Ever been anemic	Y or N
Sinus tenderness	Y or N	Blood transfusions	Y or N
Head		Taken/Taking B12 shots	Y or N
Change in facial features	Y or N	Prolonged bleeding	Y or N
Increasing roundness of face	Y or N	Eat ice frequently	Y or N
Headaches	Y or N	**Male Genital**	
Mouth		Redistribution/Loss of genital hair	Y or N
Dental problems	Y or N	Testicular shrinkage	Y or N
Dryness	Y or N	Difficulty obtaining erection	Y or N
Oral ulcers	Y or N	Lumps/swelling on testicle	Y or N
Oral thrush	Y or N	**Female Genital/Gynecological**	
Cardiovascular		Loss of libido	Y or N
Racing heart rate	Y or N	Infertility	Y or N
Palpitations	Y or N	Loss of menstrual regularity	Y or N
Dizziness	Y or N	Frequent UTI's	Y or N
Swelling of feet/ankles	Y or N	Loss vaginal lubrication/dryness	Y or N
Sleeps on > than 2 pillows	Y or N	Vaginal discharge	Y or N
Chest tightness/pressure	Y or N	Abnormal menstrual bleeding	Y or N
Chest discomfort on exertion	Y or N	Menopause/loss of menstrual cycles	Y or N
		Use of IUD/birth control	Y or N

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Review of Systems continued			
Female Obstetric		**Neurological**	
Ever been pregnant?	Y or N	Fainting/syncope	Y or N
Miscarried	Y or N	Lightheadedness	Y or N
Abortion	Y or N	Blackouts	Y or N
C-section	Y or N	Tremors in hands/feet	Y or N
Integument/Skin		Seizures	Y or N
Gynecomastia (male breasts)	Y or N	Change in handwriting	Y or N
Soreness of breasts	Y or N	Gait disturbance/unsteadiness of walking	Y or N
Breast discharge	Y or N	Temporary/chronic memory loss	Y or N
Enlargement of breasts	Y or N	Numbness/Tingling/Burning (circle if Y)	Y or N
Hx. of breast cancer	Y or N	Painful feet/legs	Y or N
Skin problems/ulcers (circle)	Y or N	Loss of smell sensation	Y or N
Itching	Y or N	**Psychiatric/Mood**	
Easy bruising	Y or N	Insomnia/Falling or staying asleep	Y or N
Eczema	Y or N	Difficulty concentrating	Y or N
Hives	Y or N	Anxiety/Nervousness	Y or N
Palmar erythema	Y or N	Depression	Y or N
Striae	Y or N	Loss of temper easily	Y or N
Nodules/Lipomas/Gangliomas	Y or N	Work/family problems	Y or N
Hair loss	Y or N	Thoughts of suicide	Y or N
Dry/rough/thick skin recently	Y or N	Sexual difficulties	Y or N
Nails breaking/splitting easily	Y or N	**Endocrine**	
Musculoskeletal		Feel hot/cold (circle 1)most of the time	Y or N
Joint pain	Y or N	Skin color darkening more than normal	Y or N
Joint swelling	Y or N	Salt craving	Y or N
Back pain	Y or N	Excessive thirst	Y or N
Shoulder pain	Y or N	Ever been told you are sterile	Y or N
Generalized muscle pain	Y or N	Size increase in hat, ring, shoe, glove	Y or N
Swollen/painful big toe	Y or N	Facial swelling/enlargement	Y or N
Leg cramps at night	Y or N	Unusually increased facial/body hair	Y or N
Leg pain when walking	Y or N	Taking insulin	Y or N
Fractured/broken any bones	Y or N	When was insulin started ________	
Increased size of feet	Y or N	Recent vision test?	Y or N
Increased size of fingers	Y or N	Do you see a podiatarist?	Y or N
Noticeable muscle loss	Y or N		
Muscle weakness	Y or N		
Take calcium/Vitamin D	Y or N		
Chronic steroid use	Y or N		
Leg pain on ambulation	Y or N		
General/Constitutional			
Unusual weight loss _____ lbs	Y or N		
Unusual weight gain _____lbs	Y or N		
Recent loss of appetite	Y or N		
Fatigue easily	Y or N		
Weakness	Y or N		
Fever/chills	Y or N		
Night sweats	Y or N		
Hypoglycemic episodes_____/month	Y or N		

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