New Patient History Form

Physician:______________________ **Date:**_______________________

Patient Information		
Full Name:		
Address:		
Home Phone#:	Business Phone#:	Mobile #:
Birthday:	Birth Place:	Age:
Nationality:	Sex: ☐ Male ☐ Female	
Marital Status: ☐ Single ☐ Separated	☐ Married ☐ Widowed	☐ Divorsed ☐ Significant Other
May we leave messages on your answering machine/voicemail? ☐ Yes ☐ No		
Please provide name(s) of individuals with contact information and relationship to you for individuals we may talk to in reference to your medical information: NAME: ______________________ RELATIONSHIP: ________________ PHONE #: (____)_____________ NAME: ______________________ RELATIONSHIP: ________________ PHONE #: (____)_____________ NAME: ______________________ RELATIONSHIP: ________________ PHONE #: (____)_____________		

Insurance & Payment Information (Insurance card required upon arrival of your appointment)	
Primary Insurance:	
Name of policy holder:	
Insurance name:	
Policy #:	Group #:
Employer:	
Secondary Insurance:	
Name of policy holder:	
Insurance name:	
Policy #:	Group #:
Employer:	

Physician Information	
Primary Care Physician:	
Name	Phone Number:
Referring Physician:	
Name	Phone Number:

Medical Informations & Questions
Please list your medical problems:

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Previous Operations/Surgery:

Type of Surgery: ____________________________ Date: ____________________________
Hospital Performed: __________________________ Name of Surgeon: _________________

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Hospital Performed: __________________________ Name of Surgeon: _________________

Type of Surgery: ____________________________ Date: ____________________________
Hospital Performed: __________________________ Name of Surgeon: _________________

Other reasons you have been hospitalized:

Have you had an allergy or sensitivity to a medication or other substance? (List the medication / substance and your reaction):

Current Medications: Prescription and Non-Prescription (over-the-counter)

Medication	Dose Amount	How often taken

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Have you have received the following vaccinations and date it was last given:

Influenza (Flu): ☐ Yes ☐ No Date: ___________________
Pneumovax (Pneumonia): ☐ Yes ☐ No Date: ___________________
Tetanus: ☐ Yes ☐ No Date: ___________________

Have you ever received a blood transfusion? ☐ Yes ☐ No
Date: ___________________

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Have you taken any steroids or cortisone (pills, injections, inhalers, creams) in the last year?

☐ Yes ☐ No

Please list type and dates of exposure: ____

____

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____

____

Have you ever used products/medications from a compounding pharmacy? If yes, please explain:

____

____

____

____

Do you use or have used any of the following over the counter supplements not listed above:

Supplement	**Last time/date used**
☐ Multivitamins	________________________________
☐ Iodine Tablets	________________________________
☐ Sushi/Seaweed	________________________________
☐ Vitamin Drinks	________________________________
☐ Energy Drinks	________________________________
☐ Atkins Drinks	________________________________
☐ Boost Power Bar	________________________________
☐ Other Supplements	________________________________

Procedure/Test/Meds	**Date Performed**
☐ IV Contrast for CT Scan	
☐ Heart Catheterization	
☐ Amiodarone	
☐ Cough Suppressant	

Please list what type of other supplements have you used and when? : ____________________

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Menstrual/Obstetric History (women only) ♀

Date of last period: ___________________ ☐ Regular ☐ Irregular

Number of pregnancy: ______ Number of Miscarrage: ______ Number of abortion: ______

☐ Ceasarian ☐ Normal Delivery

Did you breastfeed? ☐ Yes ☐ No

Please list if there are any prenancy complications: _______________________________________

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____

Social History:

Do you use tobacco currently? ☐ Yes ☐ No How long? ______

Did you smoke in the past? ? ☐ Yes ☐ No How long? ______

Do you drink alcoholic drinks? ☐Yes ☐No Have you consume alcohol in the past? ☐Yes ☐No

Type of alcohol? ______________________ Weekly mount of alcohol? ___________________

When was the last time you used narcotic pain medication? ______________________________

Do you exercise? ☐ Yes ☐ No If yes, how often & what type? ________________________

____

Family History:

Please indicate any blood relative who have/had the following conditions

Diabetes _______________________________ Osteoporosis ____________________________

Pituitary disease _________________________ Heart disease ____________________________

Cancer ________________________________ Infertility problems ________________________

Thyroid disease __________________________ High blood calcium ________________________

Hypertension ____________________________ Autoimmune disease ______________________

Adrenal gland disease _____________________ Thyroid Cancer ___________________________

Obesity ________________________________ Kidney stones ____________________________

Please briefly describe the reason you have to see the endocrinologist today?

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Please check yes or no to each of the following questions below:

General

☐ Yes ☐ No Do you have problems with fevers?

☐ Yes ☐ No Any increase or decrease in appetite?

☐ Yes ☐ No Any increase or decrease in weight in the last year?

☐ Yes ☐ No Do you have fatigue that prevents you from doing daily activities?

☐ Yes ☐ No Do you have trouble sleeping?

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Eyes

☐ Yes ☐ No Do you have double or blurry vision?
☐ Yes ☐ No Any problems with your peripheral vision?
☐ Yes ☐ No Do you have sensitivity to sunlight?
☐ Yes ☐ No Do you have eye pain?
☐ Yes ☐ No Do you have any bulging of your eyes?
☐ Yes ☐ No Do you have excessive tearing of your eyes?

Ears, Nose, Throat

☐ Yes ☐ No Do you have decreased hearing?
☐ Yes ☐ No Do you have trouble swallowing?
☐ Yes ☐ No Have you had any other changes in your voice?
☐ Yes ☐ No Has your voice been persistently hoarse?
☐ Yes ☐ No Do you have any trouble smelling aromas like coffee?
☐ Yes ☐ No Do you have clear fluid coming from your nose?

Cardiovascular

☐ Yes ☐ No Have you ever felt faint or passed out?
☐ Yes ☐ No Do you have leg cramps when walking?
☐ Yes ☐ No Does your heart race or thump?
☐ Yes ☐ No Do you have chest pressure or tightness when walking or working?
☐ Yes ☐ No Are you having trouble with chest pain?

Lungs

☐ Yes ☐ No Has your family ever said you stop breathing while you sleep?
☐ Yes ☐ No Any shortness of breath when laying flat?
☐ Yes ☐ No Do you snore?

Gastrointestinal

☐ Yes ☐ No Have you ever had jaundice or liver failure?
☐ Yes ☐ No Has a doctor ever told you that you have stomach or duodenal ulcers?
☐ Yes ☐ No Do you have diarrhea or frequent bowel movements?
☐ Yes ☐ No Do you have constipation?
☐ Yes ☐ No Do you have frequent nausea or vomiting?

Musculoskeletal

☐ Yes ☐ No Do your arms get tired when doing task above your head?
☐ Yes ☐ No Have you lost strength in your arms or legs?
☐ Yes ☐ No Do you have frequent muscle cramps?
☐ Yes ☐ No Do you have trouble standing from a seated position?

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Skin

☐ Yes ☐ No Do you have dark purple stretch marks anywhere on your body?
☐ Yes ☐ No Do you have increasing numbers of skin tags?
☐ Yes ☐ No Do you experience dry skin?
☐ Yes ☐ No Have you experienced excessive unwanted hair growth?
☐ Yes ☐ No Have you experienced any loss of body hair?
☐ Yes ☐ No Have you noticed any changes in the color of your skin?
☐ Yes ☐ No Do you have any problems with your fingernails or toenails?
☐ Yes ☐ No Do you have night sweats or hot flashes?
☐ Yes ☐ No Do you have excessive perspiration?
☐ Yes ☐ No Are you bothered with frequent skin rashes?

Neurological

☐ Yes ☐ No Do you have numbness, tingling, or pain of the hands or feet?
☐ Yes ☐ No Do you have frequent headaches?
☐ Yes ☐ No Do you suffer from any tremors or shaking of your hands?
☐ Yes ☐ No Do you experience any hand or foot spasms or cramps?

Psychiatric

☐ Yes ☐ No Do you have any history of mental problems?
☐ Yes ☐ No Do you have any restlessness?
☐ Yes ☐ No Do you have any anxiety?
☐ Yes ☐ No Do you suffer from uncontrolled depression?

Endocrine

☐ Yes ☐ No Do you persistently have problems with a low potassium level?
☐ Yes ☐ No Do you have persistent and frequent salt cravings?
☐ Yes ☐ No Do you have problems with high or low blood pressure?
☐ Yes ☐ No Do you have problems with low blood sugar?
☐ Yes ☐ No Have you ever had any broken bones?
☐ Yes ☐ No Do you feel hot or cold in a room that is comfortable for others?
☐ Yes ☐ No Do you have excessive urination?
☐ Yes ☐ No Do you experience excessive thirst?