

Printed Patient Name: _____ Date of Birth: _____
 REASON FOR VISIT: _____ Today's Date: _____
 Referring Physician: _____

**Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.*

MEDICAL HISTORY: (Mark All that Apply)

Thyroid	Diabetes
Hypothyroidism (underactive Thyroid)	Age at Diagnosis:
Hyperthyroidism (overactive Thyroid)	Symptoms at Diagnosis:
Thyroid Nodule – Date Diagnosed:	Date started Medication:
Thyroid Cancer – Date Diagnosed:	Date started Insulin:
Heart	Retinopathy
High Blood Pressure	Date of Last Eye Exam
High Cholesterol	Laser Therapy
Heart Attack	Neuropathy
Heart Failure	Increased Urinary Protein
Angioplasty / Stent	Cancer
Atrial Fibrillation / Flutter	No Yes Type:
Stroke	Neuro / Psychiatric
Lung	Seizures
Asthma	Neuropathy
COPD / Emphysema	Stroke
Sleep Apnea	Migraine
Other:	Eating Disorder
Bone	Alcoholism
Osteopenia	Addiction
Osteoporosis	Depression
Hip Fracture	Anxiety
Spine Fracture	Other:
Wrist Fracture	GYN
GI	Date of First Period Regular Irregular
Hepatitis	How Many Pregnancies
Celiac Disease	Last Period
GERD/Reflux	Hormone Replacement
Gallstones	Other Medical Conditions
Other:	1.
Kidney Disease	2.
Abnormal Kidney Function	3.
Dialysis	4.
Kidney Transplant	5.
Kidney Stones	6.

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SURGICAL HISTORY: (Mark All that Apply and Indicate Date Performed)

Heart Bypass	Gallbladder
Angioplasty/Stent	Thyroid Surgery
Leg Bypass	Pituitary Surgery
Hip Replacement	Other Surgeries:
Hysterectomy	1.
Ovaries Removed: yes no	2.
	3.

CURRENT MEDICATIONS :

NAME	DOSE	FREQUENCY	INDICATION

MEDICATION ALLERGIES: **No Known Allergies** If yes, complete below:

Drug Name	Reaction

SOCIAL HISTORY:

Marital Status: _____ Children: ___ Girls ___ Boys
Occupation: _____
Smoking: Current Maximum packs/day _____
 Former Number of years smoked _____ Year quit _____
 Never
Alcohol: _____ Drinks per week
Caffeine: _____ per day
Exercise type and frequency: _____
Special Diet / Type / Restrictions: _____

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FAMILY HISTORY: (Mark All that Apply and List Family Member)

	Family Member		Family Member
Diabetes:			Thyroid Nodule
Adult Onset/Type II			Goiter
Juvenile Onset/Type I			Thyroid Cancer
High Blood Pressure			Calcium Disorder
High Cholesterol			Parathyroid Disease
Heart Attack			Osteoporosis
Stroke			Hip Fracture
Hypothyroid/Underactive			Kidney Stones
Hyperthyroid/Overactive			Adrenal Disease
Cancer			Pituitary Disease
Other:			Other:

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	Cardiovascular	Genitourinary
Weight Gain	Chest Pain	Pain with Urination
lbs. in months/yrs.	Heart Attack	Frequent Urination
Weight Loss	Heart Murmur	Blood in Urine
lbs. in months/years	Palpitations	Urinating Overnight
Sleeping Problems	Irregular Heart Beat	Number of times per night
Fatigue	Shortness of Breath w/Walking	Hesitation with Urination
Fevers/Chills/Sweats	Dizziness	Incomplete Voiding
Skin	Swelling of Feet/Ankles	Lack of Bladder Control
Skin Rash	Gastrointestinal	Men:
Itching	Nausea / Vomiting	Erectile Dysfunction
New Skin Marks/Spots	Vomiting Blood	Changes in libido
Head/Eyes/Ears/Nose/Throat	Difficulty Swallowing	Fertility problems
Visual Problems / Changes	Heartburn/Indigestion	Pain or changes in Penis/Testicles
Type:	Abdominal Pain	Testicular Mass / Breast Lump
	Constipation / Diarrhea	Women:
Voice Changes	Reflux / Bloating	Pre-menopausal
Sinus Infections	Neurological / Psychiatric	Per-menopausal
Hoarseness	Headache / Light-headedness	Post-menopausal
Sore Throats	Numbness / Tingling	Irregular Periods
Headaches	Dizziness / Vertigo / Fainting	Fertility Problems
Respiratory	Balance Problems / Falling	Prior Pregnancy
Coughing	Changes in Mood	Prior Miscarriage/Abortion
Wheezing	Concentration/Memory changes	Nipple Discharge
Shortness of Breath	Anxiety / Depression	Hot Flashes
Bone / Muscle	Endocrine	Endocrine (Continued)
Joint Pain	Excessive Thirst	Feeling of lump in neck
Muscle Pain	Excessive Urination	Tremor
Bone Pain	Intolerance to heat/cold	Low Blood Sugar Reaction
Back Pain	Changes to Skin/Hair/Nail	Frequency:
Other:	Describe:	Other:

Patient Signature: _____ Date: _____