Endocrinology Specialists of McKinney

HEALTH HISTORY FORM

Name _____ __ Date of Birth _____ Date _____

Welcome to our practice!! We are happy you chose us to assist you with your health care needs. Please help us by completing both sides of this form. This is a confidential record that will be kept in your chart in this office.

Who referred you? _____

Past Medical History: Have you ever had the following? (Circle yes or no. Leave blank if you are unsure.)

Asthma . . . . . no yes
Emphysema . . . . . no yes
Heart Disease . . . . . no yes
High blood pressure . . . no yes
High cholesterol . . . . . no yes
Thyroid disease . . . . . no yes
Diabetes . . . . . no yes
Cancer . . . . . no yes
Bladder infections . . . . no yes
Kidney disease . . . . . no yes
Ulcer . . . . . no yes
Liver disease . . . . . no yes
Back problems . . . . . no yes
Arthritis . . . . . no yes
Any other disease (please list)

_____
_____

When was your last:
Mammogram _____
Prostate exam _____
PSA test _____
Tetanus shot _____
Pneumonia shot _____
Flu shot _____
Hepatitis A & B shots _____
Bone Density _____

Serious Illnesses, Surgeries & Hospitalization: (please list with date of occurrence)

_____
_____
_____

Allergies: (foods, drugs) Please indicate type of reaction.

_____
_____
_____

Family History: Please indicate in the spaces below any family members with a history of: diabetes, heart disease, stroke, thyroid cancer, pituitary tumors, gastric tumors, adrenal tumors, kidney disease/ kidney stones, high blood pressure, gout, gastric ulcer

	Age	**Health Problems**	**Age at Death**	**Cause**
Father	_____	_____	_____	_____
Paternal Grandfather		_____		
PaternalGrandmother		_____		
Mother	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Sons	_____	_____	_____	_____
Daughters	_____	_____	_____	_____

Any other family members with illnesses noted above?
_____
_____

Social History:
Marital Status: _____ Highest level of education: _____
Occupation: _____Frequency/amount of alcohol use: _____
Frequency/amount of tobacco use: _____Frequency/amount of drug use:
_____ Frequency/amount of caffeine: _____

Current Medications: (include non-prescription medications and vitamins or supplements):
_____
_____
_____
_____
_____
_____

Other Doctors you see: Specialty
_____
_____
_____
_____

Review of Systems: *(Check all symptoms you have had recently)*

Constitutional
__ Loss of appetite
__ Fatigue
__ Weight change over 10 lbs

Eyes
__ Blurry vision
__ Double vision
__ Eye discomfort or irritation

Ears, Nose, Mouth, Throat
__ Sore throat
__ Sores or lumps in mouth
__ Hoarseness of voice

Cardiovascular
__ Chest discomfort
__ Irregular or rapid heartbeat

Respiratory
__ Cough
__ Shortness of breath
__ Wheezing

Integumentary
__ skin rash or lesions
__Hair changes
__ Purple stretch marks
__ Breast lumps
__ Discharge from breast
__ Abnormal lumps or growths

Gastrointestinal
__ Nausea or vomiting
__ Constipation
__ Diarrhea
__ Difficulty swallowing
__ Heartburn
__ Increase in abdominal size

Genitourinary
__ Discomfort with urination
__ Excess urination
__ Difficulty urinating
__ Red or bloody urine

Endocrine
__ Excessive thirst or urination
__ Intolerance of hot or cold
__ Excessive perspiration

Musculoskeletal
__ Muscle aches
__ Muscle weakness
__ Backache
__ Joint discomfort or stiffness
__ Increase in shoe or ring size

Neurologic
__ Headache
__ Dizziness
__ Numbness or tingling
__ Tremor or shaking
__ Fainting or blackouts
__ Sleep disturbance

Psychiatric
__ Sadness or depression
__ Anxiety or nervousness

Hematologic Lymphatic
__ palpable lymph nodes in neck or under arms
__ Abnormal bleeding or bruising

Please Sign: _____
Date_____