Baylor Endocrine Center

Dr. Priscilla Hollander, M.D., PhD **Dr. Erin Roe, M.D.** **Kristy Eckelberry–Schuh, RN, NP**

FULL MEDICAL HISTORY SURVEY

Name ______________________________ **Date** ______________

Primary Care Doctor's Name and Address
____
____
____
Ph:____________Fax:____________

Are there any other doctors you see regularly who would like to receive updates on our clinical visits?
____
____
____
Ph:____________Fax:____________

Preferred Pharmacy (Store Name/Street/City)
____
____

PERSONAL MEDICAL HISTORY

Please list all the medical problems/diseases you have been diagnosed with ______________________________
____
____
____
____
____
____
____

Please list any operations or hospitalizations______________
____
____
____

Do any diseases run in your family? (cancer, heart disease, thyroid problems)______________________________
____
____

Have you ever been diagnosed with diabetes? (circle)
Type 1 Type 2 Gestational
When were you diagnosed? (year)______________
Initial Diabetes Rx______________
Length of time on initial Rx ______________
Date started insulin ______________
Type of insulin and dose______________
Have you been diagnosed with diabetic eye changes (retinopathy) ? Yes No
When was your last eye exam? ______________
Who is your eye doctor?______________

Family history of diabetes:______________
____

Have you ever fractured a bone as an adult? Yes No
Do you take extra calcium and/or vitamin D? Yes No
Have you ever been treated with hormone replacement therapy (estrogen or testosterone)? when______________
Have you taken medicines for osteoporosis/low bone density?
____
Have you had any falls in the past year? Yes No

LIFESTYLE

Do you exercise? (circle) Yes No
How often?______________
What type of exercise?______________

Do you follow a special diet?______________
Have you ever had high triglycerides or cholesterol? Yes No

Do you drink alcohol? (circle) Yes No
If yes, please indicate frequency:
____Infrequently (1-2 times per month or year)
____Occasionally (1-2 times per week)
____Moderately (1-2 times per day)
____Often (more than twice a day)
____Other (please be specific) ______________

Have you ever been a heavy drinker? Yes No
When?______________
Have you ever been treated for drug or alcohol abuse?_______

Do you smoke or use tobacco in any form? Yes No
Did you smoke in the past? When?______________
If yes, what is the form you used and what was the frequency?
____
What is your occupation?______________
Marital Status: single married/partnered divorced widow

For women, please indicate:
Year of first period: ______________
Date of last menstrual period/menopause______________
pregnancies______# children_______ ages______________
Are you currently sexually active? Yes No
Method of birth control?______________
Are you currently breastfeeding?______________

Do you have any allergies? Please list and include reaction:
____
____

Name ____Date ___________________________

Please circle any of the symptoms you have had in the past three months

General

Symptom		
Appetite decreased	Yes	No
Appetite increased	Yes	No
Excessive sweating	Yes	No
Fatigue	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No

Eyes

Symptom		
Eyes bulging	Yes	No
Eye irritation	Yes	No
Eye pain	Yes	No
Double vision	Yes	No
Blurred vision	Yes	No
Vision loss	Yes	No
Cataract	Yes	No
Glaucoma	Yes	No

Ear/Nose/Throat

Symptom		
Decreased hearing	Yes	No
Difficulty swallowing	Yes	No
Nosebleeds	Yes	No
Hoarseness	Yes	No
Nasal congestion	Yes	No
Masses	Yes	No
Sore throat	Yes	No
Ringing in the ears	Yes	No

Cardiovascular

Symptom		
Bluish discoloration of lips and nails	Yes	No
Chest pain or tightness	Yes	No
Difficulty breathing at night	Yes	No
Difficulty breathing while laying down	Yes	No
Fainting	Yes	No
Leg cramps with exertion	Yes	No
Chest pain	Yes	No
Lightheadedness	Yes	No
Palpitations	Yes	No
Raising/skipping heartbeats	Yes	No
Shortness of breath with exertion	Yes	No
Swelling of hands or feet	Yes	No

Pulmonary

Symptom		
Coughing up blood	Yes	No
Shortness of breath	Yes	No
Snoring	Yes	No
Sleep disturbances from breathing	Yes	No
Wheezing	Yes	No

Gastrointestinal

Symptom		
Abdominal pain	Yes	No
Abdominal bloating	Yes	No
Acid reflux/indigestion	Yes	No
Change in bowel habits	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Gas	Yes	No
Nausea	Yes	No
Yellowish skin change	Yes	No
Vomiting	Yes	No
Gallstones	Yes	No

Urinary

Symptom		
Pain with urination	Yes	No
Urine infection	Yes	No
Kidney stones	Yes	No
Kidney infection	Yes	No
Bloody urine	Yes	No
Decreased libido	Yes	No
Difficulty attaining erection	Yes	No
Difficulty maintaining erection	Yes	No
Difficulty starting urine stream	Yes	No

Reproductive

Symptom		
Heavy periods	Yes	No
Missed periods	Yes	No
Painful periods	Yes	No
Hot flashes	Yes	No
Vaginal yeast infection	Yes	No
Pain in testicles	Yes	No
Breast pain	Yes	No
Breast discharge	Yes	No

Musculoskeletal

Symptom		
Arthritis	Yes	No
Back pain	Yes	No
Joint pain	Yes	No
Joint swelling	Yes	No
Loss of strength	Yes	No
Muscle aches	Yes	No
Muscle cramps	Yes	No
Muscle mass increased	Yes	No
Muscle wasting	Yes	No
Stiffness	Yes	No

Dermatology

Symptom		
Change of color of skin	Yes	No
Dryness	Yes	No
Purple or pink stretch marks	Yes	No
Darkening scars	Yes	No
Flushing	Yes	No
Night sweats	Yes	No
Poor wound healing	Yes	No
Rash	Yes	No
Unusual hair distribution	Yes	No
Fungus infection	Yes	No
Athlete's foot	Yes	No

Neurological

Symptom		
Burning/electrical pain	Yes	No
Difficulty with concentration	Yes	No
Disturbances in coordination	Yes	No
Falling down	Yes	No
Fainting	Yes	No
Headaches	Yes	No
Numbness	Yes	No
Poor balance	Yes	No
Seizures	Yes	No
Sensation of room spinning	Yes	No
Tingling	Yes	No
Tremors	Yes	No
Weakness	Yes	No

Mental Health

Symptom		
Anxiety	Yes	No
Depression	Yes	No
Mental problems	Yes	No
Frightening visions or sounds	Yes	No
Thoughts of suicide	Yes	No
Thoughts of violence	Yes	No

Endocrinology

Symptom		
Excessive hunger	Yes	No
Excessive thirst	Yes	No
Excessive urination	Yes	No
Intolerance to cold	Yes	No
Intolerance to heat	Yes	No

Hematology

Symptom		
Abnormal bruising	Yes	No
Bleeding	Yes	No
Enlarged lymph nodes	Yes	No
Skin discoloration	Yes	No

Infection/Allergy

Symptom		
HIV exposure	Yes	No
Tuberculosis exposure	Yes	No
STD	Yes	No
Pipes or rash	Yes	No
Persistent infections	Yes	No
Seasonal allergies	Yes	No

Name ____Date ____________________________

What medications are you now taking or have you taken in the last three months? (Please include any non-prescription medicines, e.g., vitamins, supplements, herbals, aspirin, cold tablets, or laxatives.)

Medication	Dosage	Frequency	Reason	Start Date	Stop Date

Please your top three questions/concerns we can help to address in first visit?

1)

2)

3)

Please bring any outside records include lab tests, biopsy reports, operative reports and doctors records you have.

We look forward to meeting you!