ABILENE ENDOCRINOLOGY, PA
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New Patient History Form (Male, Non-diabetic)

Name:	**DOB:**
Today's Date:	**Visit Date:**
What is the reason for your visit today?	
Who referred you here?	
Who is your primary care provider?	
To whom would you like us to send a copy of today's visit report?	

The following are questions about your past medical history, social history, and family history. Please fill out all sections. If more room is needed, please use the last page of this form. Please complete as best you can prior to your visit.

PAST MEDICAL HISTORY

Please list current and past medical diagnoses (e.g. high blood pressure, high cholesterol):

Diagnosis	Approximate Date Diagnosed	Description
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Please list all previous hospitalizations:

Reason	Date	Facility	Description
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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Name: _____

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Please list all previous operations/procedures (e.g. tonsillectomy, appendectomy, colonoscopy):

Procedure	Date	Facility	Description
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Immunizations:		Medication Allergies:	
Type	Approximate Date	Medication	Reaction
Influenza			
Measles			
Mumps			
Rubella			
Pneumonia			
Tetanus		Food/Environmental Allergies:	
Zoster		Food/Allergen	Reaction
Varicella			
Hepatitis B			
Hepatitis A			
Meningococcal			
Other			

MEDICATION HISTORY

Please list all current prescription medications, over-the-counter medications, and supplements:

Medication Name	Dose	Frequency Taken	Start Date	Prescribed By:
1				
2				
3				
4				
5				
6				
7				
8				
9				

Name: _____

DOB: _____

MEDICATION/SUPPLEMENT HISTORY

Have you ever taken any of the following medications/supplements?

Medication/Supplement	Yes/No	Start Date and Duration of Use	Reason for Use
Glucocorticoid (e.g. prednisone)			
Seizure/Mood Medications (e.g. Dilantin)			
Body/Muscle Building Supplement (e.g. testosterone-booster, estrogen blocker)			
Antidepressants			
Lupron			
Fertility Medications			
Haldol or Thorazine			
Reglan (metoclopramide)			

HABITS:

Do you smoke cigarettes? Please circle one.	How many alcoholic beverages do you drink?
Never	Per day_____
Current	Per week_____
Age started_____	
Packs per day_____	Have you ever used (circle if yes):
Former Age started_____	Cocaine Heroin
Year Quit_____	Ecstasy Marijuana
Average packs per day_____	Amphetamines IV Drugs
Do you use smokeless tobacco? Please circle one.	**Physical Activity**
Never	How active are you?_____
Current	Type of exercise:_____
Age started_____	Duration of exercise:_____
Type _____	Frequency of exercise:_____
Former	How many caffeinated drinks do you have daily?
Age started_____	Coffee cups:_____
Year Quit_____	Cans of soda:_____
Type _____	Other:_____

SOCIAL HISTORY

Please only answer questions that you feel comfortable doing so.

Are you (circle one): Single Married Separated Divorced Widowed

Are you (circle one): Heterosexual Bisexual Homosexual Prefer not to answer

Have you ever had a sexual relationship with someone of the same sex (circle one)? Yes No Prefer not to answer

Who do you live with?_____

What is your occupation?_____

Name: _____

DOB: _____

FAMILY HISTORY

Are you adopted (circle one)? YES NO

Does anyone in your family (including siblings, parents, grandparents, aunts, uncles, children) have any of the following diagnoses?

Diagnosis	Relation	Age at diagnosis	Comments
Diabetes			
High Cholesterol			
High Blood Pressure			
Heart Attack/Heart Disease			
Vascular Disease			
Stroke			
Brain Tumor			
Pituitary Tumor			
Underactive Thyroid			
Overactive Thyroid			
Hashimoto's Thyroiditis			
Graves' Disease			
Goiter			
Thyroid Cancer			
Adrenal Gland Tumors			
Adrenal Insufficiency			
Hypercalcemia			
Kidney Stones			
Osteoporosis/Fractures			
Clotting Disorder			
Kidney Disease			
Lupus			
Rheumatoid Arthritis			
Celiac Disease			
Other autoimmune disorder			

Other than that listed above, please list medical problems and status for the following relatives:

Mother

Age if living_____

Age of death_____

Medical problems:_____

_____

Continued on following page.

New Patient History Form, Page 5

Name: _____

DOB: _____

Family history continued from previous page.

Father

Age if living_____

Age of death_____

Medical problems:_____

_____

Mother's Parents:

Medical problems:_____

_____

_____

_____

Father's Parents:

Medical problems:_____

_____

_____

_____

Siblings (list sex, current age)

Medical problems:_____

_____

_____

_____

Children (list sex, current age)

Medical problems:_____

_____

_____

_____

SYMPTOM REVIEW

Please review the following problems/symptoms and circle those that are positive.

Symptom/Problem	Description	Symptom/Problem	Description
Fever		Previous head injury	
Fatigue		Headache	
Weakness		Blurred vision	
Weight change		Double vision	
Night sweats		Change in vision	
Change in work or school performance		Dry eye	
Change in appetite		Red eye	
Change in shoe, hat or ring size		Cataract	
Sluggish		Eye irritation	
Drowsy		Change in tooth spacing	

Continued on next page.

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Name: _____

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Symptom review continued from previous page.

Symptom/Problem	Description	Symptom/Problem	Description
Inability to smell		Swollen glands	
Ringing in ears		Goiter	
Frequent ear infection		Pain in neck	
Hearing loss		Pressure in neck	
Earaches		Trouble swallowing	
Change in speech		Swelling in neck	
Dental problems		Heart Disease	
Sore throat		Heart failure	
Frequent sinus infection		Chest pain	
Runny nose		Chest pressure	
Bloody nose		Chest tightness	
Hoarse voice		Palpitations	
Cough		Leg/Ankle swelling	
Wheezing		High blood pressure	
Pain with breathing		High cholesterol	
Tuberculosis		Heart murmur	
Tuberculosis exposure		History rheumatic fever	
Wake at night with trouble breathing		Short of breath with exertion	
Chronic lung disease		Irregular heart beat	
Snoring		Racing heart beat	
Difficulty falling asleep		Leg pain with walking	
Early morning waking		Vascular disease	
Dozing off while driving		Nausea	
Restless leg syndrome		Vomiting	
Change in need for sleep		Reflux	
Pancreatitis		Indigestion	
Hemorrhoids		Abdominal pain	
Bloating		Constipation	
Liver disease		Diarrhea	
Hepatitis		Irritable bowel syndrome	
History of anemia		Black/tarry stool	
Easy bruising		Blood in stool	
Easy bleeding		Ulcer	
History of blood clots		Gallstones	
History of phlebitis		Yellow skin	

Continued on following page

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Name: _____

DOB: _____

Symptom review continued from previous page.

Symptom/Problem	Description	Symptom/Problem	Description
Fractures		Hair loss	
Bone density scan		Change in underarm and/or pubic hair	
Sexual dysfunction		Change in shaving frequency	
Change in sexual desire		Rash	
Impotence		Skin lumps	
Infertility		Skin cancer	
Change in testicles		Dry skin	
History of STD		Tan that won't go away	
Blood in urine		Hair thinning	
Difficult urination		Hair breaks easily	
Painful urination		Brittle nails	
Enlarged prostate		Acne	
Prostate cancer		Oily skin	
Night time urination		Hot flashes	
History of urinary infection		Increased thirst	
Urinary urgency		Frequent urination	
Kidney Stones		Always cold	
Vasectomy		Always hot	
Lump in testicle		Sweat easily	
Breast enlargement		Thyroid problem	
Nipple discharge		High calcium	
Joint pain		History of head/neck radiation	
Muscle pain		Dizziness	
Joint stiffness		Fainting/blackout spell	
Swollen joints		Seizure disorder	
Rheumatoid arthritis		Tremor	
Lupus		Unsteady gait	
Osteoarthritis		Numbness or tingling	
Gout		Finger/toe pain	
Thin bones		Carpal Tunnel syndrome	
Back pain		Seasonal allergies	
Degenerative joint disease		Hives	
Mood Swings		Latex allergy	
Depression		Irritability	
Anxiety		History of psychosis	
Thoughts of suicide		Other	

Name: _____
DOB: _____

Please use this area for any additional information or comments.