Carolina Endocrine, PA

Adult Medical History Form

Name:_____ DOB:_____ Age:_____ Date:_____

Reason for today's visit: _____

PERSONAL MEDICAL HISTORY (check all that apply)

- □ Hypothyroidism
- □ Hyperthyroidism
- □ Thyroid nodule
- □ Thyroid cancer
- □ Osteoporosis
- □ Menopause
- □ Infertility
- □ Polycystic ovarian syndrome
- □ Low testosterone
- □ Low vitamin D
- □ High calcium
- □ Low calcium
- □ Pituitary tumor
- □ Adrenal tumor
- □ Diabetes mellitus
- □ High blood pressure
- □ High cholesterol
- □ Heart attack
- □ Stroke
- □ Kidney disease
- □ Kidney stones
- □ Depression
- □ Anxiety
- □ Cancer (type:_____)
- □ Other _____

SURGICAL HISTORY

Procedure	Date	Procedure	Date
1.		5.	
2.		6.	
3.		7.	
4.		8.	

MEDICATION ALLERGIES: _____

MEDICATIONS List all medications you are currently taking with dosage (including vitamins and supplements)

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

FAMILY HISTORY □ Check if adopted or family history unknown

Please check all that apply	Father	Mother	Grandfather		Grandmother		Brother(s)	Sister(s)
			Paternal	Maternal	Paternal	Maternal		
Thyroid disease								
Diabetes								
Osteoporosis								
Heart disease								
High blood pressure								
Cancer If yes, type:								

SOCIAL HISTORY

Occupation: _____ Marital status: □ Married □ Divorced □ Widowed □ Single

Have Children: □ No □ Yes If yes, # of pregnancies _____ # of live births _____

Exercise: □ No □ Yes If yes, # of hours per week _____

Tobacco use: □ Never smoked

□ Currently smoking # of packs per day _____ # of years_____

□ Quit smoking Age started_____ Age stopped_____

Alcohol use: □ No □ Yes If yes, specify # of drinks per week: _____

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Review of Symptoms Form

PATIENT NAME:_____ DOB: _____ TODAY'S DATE: _____

In the last 6 months have you experienced any of the following symptoms? (please check all that apply)

Constitutional
□ Fatigue □ Weight loss □ Weight gain □ Insomnia
□ Fever □ Chills

Endocrine
□ Excessive sweating □ Flushing □ Heat intolerance □ Cold intolerance
□ Frequent urination □ Frequent thirst □ Change in shoe or ring size

Skin
□ Dry skin □ Hair loss □ Unwanted hair □ Breast discharge
□ Breast mass or lumps

Ears/Eyes/Nose/Throat
□ Blurred vision □ Double vision □ Dry eyes □ Difficulty swallowing

Neck
□ Neck pain □ Neck fullness □ Difficulty swallowing □ Change in neck appearance

MUSCULOSKELETAL
□ Muscle aches/weakness □ Joint pain □ Bone pain

Respiratory
□ Cough □ Shortness of breath □ Wheezing □ Snoring

Cardiovascular
□ Chest pain □ Palpitations □ Fainting □ Swelling of legs or feet

Gastrointestinal
□ Abdominal pain □ Nausea □ Diarrhea □ Vomiting
□ Constipation □ Bloating

Genitourinary
□ Urinating at night □ Frequent urination □ Absence of cycles □ Irregular cycles
□ Testicular pain □ Testicular mass □ Low libido □ Erectile dysfunction
□ Infertility

Neurological/Psychiatric
□ Tremor □ Tingling/numbness □ Difficulty concentrating □ Headaches
□ Anxiety □ Depression □ Frequent crying

Heme/lymph
□ Bruise easy □ Night sweats