ENDOCRINE AND METABOLIC SPECIALISTS, LLC.

Patient Health Information

Date:

Last name	**First name**	**Middle initial**	**Age**	**Sex**

Do you need a chaperone for this visit or future visits?

Presenting problem (reason for this Visit):

Past Medical History:

Yes	No		Yes	No	
		Diabetes			Thyroid problems
		High blood pressure			Lung problems/asthma
		High cholesterol			Kidney stones
		Heart attack			Gall stones
		Stroke			Kidney/liver/pancreas
		Bleeding/clotting problems			transplant:
		Cancer			Osteoporosis
		Hepatitis			Glaucoma
		Anemia			Cataracts
		Arthritis			Epilepsy or seizures
		Mental illness			Ulcers
		Heart murmur			Others

Surgeries: List types and dates of all surgeries you have had in the past. ____None

Year	Type of surgery	Name of facility	Complications

Have you ever had a blood transfusion? ____Yes ____No If yes Date:

List any hospital admissions or medical conditions not listed above:

Allergies: Please list the type and reaction.
____None

Name of drug/item	Reaction

Medications that you take	**Dose**	**How many times a day?**

Patient name____

Medications (continued)	**Dose**	**How many times a day?**

Names of other present MDs	**Specialty**	**Phone number**
	Internal Medicine *	
Please fill this. This information is needed.		

Have you ever used or do you now use tobacco? ____ Yes ____No
No. packs/day ________ Total number of years smoked ________
When did you quit? ________________________

Do you drink alcohol? ___Yes ___No If yes, how much do you drink on a weekly basis?________

Family History

	Yes	No	Which family member?
Diabetes			
High blood pressure			
High cholesterol			
Heart attack			
Stroke			
Bleeding/clotting problems			
Cancer			
Hepatitis			
Anemia			
Arthritis			
Mental illness			
Heart murmur			
Thyroid problems			
Lung problems/asthma			
Kidney stones			
Gall stones			
Kidney/liver/pancreas			
transplant:			
Osteoporosis			
Glaucoma			
Cataracts			
Epilepsy or seizures			
Ulcers			
Others:			

Patient name____

Females only:

OB/Gyn History	Date or no. if requested	Yes	No
Age of first period			
Date of last menstrual period			
Are your menses irregular?			
No. of days in cycles (ex., 28-30 days)			
No. of days periods last			
Any spotting between periods?			
Are you pregnant?			
Total no. of pregnancies			
No. of live births			
No. of abortions or miscarriages			
Date of last Pap smear			
Was it abnormal?			
Date of last mammogram			
Date of last bone density scan			
Are you currently using contraception?			
Type of contraception			

If female, are you pregnant? Yes / No.

If you are DIABETIC:

1. What blood glucose meter do you use?__________________
   How many times do you test per day? __________________
2. Are you on an insulin pump? Yes/No.
   If yes, which one ________________________________
3. Have you had a recent dilated eye exam? Yes /No.
   Date of exam ________________________________
4. Have you had a recent foot exam? Yes /No
   Date of exam ________________________________

Important: Please ask the doctors and/or office staff for prescriptions or refills of your medications while you are here at the office to reduce errors in handling prescriptions after the visit. We give enough refills to last you until your next visit. Thank you for your cooperation.

DO YOU NEED PRESCRIPTIONS OR REFILLS? *YES/ NO*. If yes, LIST THE MEDICATIONS BELOW:

Do you have any problems (social, religious, language, etc.) that would operate as a barrier to effectively communicate with the doctor regarding your health? Yes/ No. If yes, please explain

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