COMMUNITY CARE
ENDOCRINOLOGY
of Community Care Physicians

Susan P.Demarest, MD
Allison D. Graziadei, MD
Michael O'Rourke, PA-C

NEW PATIENT MEDICAL HISTORY FORM

Name _____ DOB _____

Appointment Date: _____

What endocrine problem would you like us to help you with? _____

Past Medical History: Please list your medical problems **diagnosed** by other doctors:

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

Past Surgical History: Please list all previous surgeries that you have had:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Please list ALL doctors that you see on a regular basis, including your primary care doctor:

Primary Care Provider: _____ Gynecologist: _____

Eye Doctor: _____ Podiatrist: _____

Surgeon: _____ Other: _____

List of Medications:

1. _____ Dose _____ Time of Day Taken _____
2. _____ Dose _____ Time of Day Taken _____
3. _____ Dose _____ Time of Day Taken _____
4. _____ Dose _____ Time of Day Taken _____
5. _____ Dose _____ Time of Day Taken _____
6. _____ Dose _____ Time of Day Taken _____
7. _____ Dose _____ Time of Day Taken _____
8. _____ Dose _____ Time of Day Taken _____
9. _____ Dose _____ Time of Day Taken _____

(cont. on next page)

10. _____ Dose _____ Time of Day Taken _____

11. _____ Dose _____ Time of Day Taken _____

12. _____ Dose _____ Time of Day Taken _____

13. _____ Dose _____ Time of Day Taken _____

14. _____ Dose _____ Time of Day Taken _____

Pharmacy Name and Address: _____

Vitamin Supplements:

1. _____ Dose _____ Time of Day Taken _____

2. _____ Dose _____ Time of Day Taken _____

3. _____ Dose _____ Time of Day Taken _____

4. _____ Dose _____ Time of Day Taken _____

5. _____ Dose _____ Time of Day Taken _____

Allergies to Medications:

1. _____ What Reaction Occurs? _____

2. _____ What Reaction Occurs? _____

3. _____ What Reaction Occurs? _____

4. _____ What Reaction Occurs? _____

5. _____ What Reaction Occurs? _____

Family History: Please list any significant medical problems suffered by immediate family members (parents, siblings, and children):

Family Member:

1. _____ Medical Condition _____

2. _____ Medical Condition _____

3. _____ Medical Condition _____

4. _____ Medical Condition _____

5. _____ Medical Condition _____

Social History:

1. Do you smoke cigarettes now? ☐ YES ☐ NO How many per day? _____

2. Did you smoke cigarettes in the past? ☐ YES ☐ NO How many per day? _____

3. Do you drink > 2 servings of alcohol per day? ☐ YES ☐ NO How many per day? _____

4. How many days per week do you exercise? _____

5. How many hours of sleep do you get per night? _____

Review of Systems: Please check all that apply to you on a regular basis.

Constitutional:

☐ Fatigue

☐ Weight loss

☐ Weight gain

☐ Drenching night sweats

Eyes:

☐ Permanent reductions in vision

☐ Bulging of your eyes

Ears/Nose/Mouth/Throat:

☐ Permanent reductions in hearing

☐ Permanent change in voice

Cardiovascular:

☐ Chest pain

☐ Racing heartbeat

☐ Persistent leg swelling

Respiratory:

☐ Shortness of breath

☐ Persistent cough

☐ Snoring at night

☐ Frequent daytime napping

(cont. on next page)

Gastrointestinal:

- ☐ Abdominal pain
- ☐ Persistent nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Abdominal bloating/gas
- ☐ Intolerance to wheat

Men Only:

- ☐ Urination >2 times/night
- ☐ Erectile dysfunction
- ☐ Difficulty starting/stopping the flow of urine
- ☐ Swelling of nipple area

Women Only:

- ☐ Urination >2 times/night
- ☐ Incontinence
- ☐ Irregular menstrual cycle
- ☐ Painful nipple or breast swelling
- ☐ Nipple discharge

Skin:

- ☐ Change in skin texture:
  - ☐ Dry/Smooth
  - ☐ Rashes
  - ☐ Wounds

Neurologic:

- ☐ Headache
- ☐ Numbness, tingling or pain in your feet
- ☐ Dizziness

Musculo-Skeletal:

- ☐ Joint pain:

Location: _____

Psychiatric:

- ☐ Anxiety
- ☐ Depression
- ☐ Feeling like hurting yourself

Endocrine:

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Enlarged thyroid gland
- ☐ Frequent urination
- ☐ Frequent thirst

Hematologic/Oncologic:

- ☐ Swollen lymph nodes
- ☐ Easy bruising/bleeding

Any Additional Symptoms: _____

_____

Supplemental Questions

If you are seeking care for Diabetes, please answer the following additional questions:

1. What type of diabetes do you have?: ☐ Type 1 ☐ Type 2 ☐ Not sure
2. When were you diagnosed with diabetes?: _____
3. Do you see an eye doctor every year? ☐ YES ☐ NO

   Name: _____ Date: _____
4. Has your eye doctor told you that diabetes has damaged your eyes?: ☐ YES ☐ NO
5. Do you have numbness or tingling in your toes from diabetes? ☐ YES ☐ NO
6. Have you had any reactions to diabetes medications? ☐ YES ☐ NO

Medication:

A. _____ Reaction: _____

B. _____ Reaction: _____

C. _____ Reaction: _____

7. Have you ever had a severe low blood sugar where you lost consciousness, crashed your car, or had to be transported to the hospital? ☐ YES ☐ NO
8. Have you ever had pancreatitis (severe inflammation of the pancreas, can't eat or drink for several days, usually requires hospitalization)? ☐ YES ☐ NO
9. Has anyone in your family ever had medullary thyroid cancer (may prevent certain types of diabetes medications from being used)? ☐ YES ☐ NO
10. What about diabetes is most bothersome to you?:

_____

_____

(cont. on next page)

If you are seeking care for Thyroid Cancer, please answer the following additional questions:

1. What year were you diagnosed with thyroid cancer? _____
2. What type of thyroid cancer? _____
3. Who performed your thyroid surgery, and at what hospital was that surgery performed?

_____

4. Were you treated with radioactive iodine after surgery? ☐ YES ☐ NO
5. When was your last neck ultrasound?: _____

If you are seeking care for Osteoporosis (low bone density), please answer the following additional questions:

1. What year were you diagnosed with low bone density?: _____
2. What year did you enter menopause?: _____ N/A
3. Did you take hormone replacement therapy after menopause?: ☐ YES ☐ NO

   If yes, for how many years?: _____
4. Have you had any fractures since menopause? ☐ YES ☐ NO

   If yes, which bones, and how did it happen?:

   i.

   ii.

   iii.
5. Did your mother ever fracture a hip? ☐ YES ☐ NO
6. How much calcium do you take on a daily basis?: _____ mg
7. How much Vitamin D do you take on a daily basis?: _____ IU
8. How many days per week do you exercise, what type of exercise?: _____

_____

9. Do you fall on a regular basis? ☐ YES ☐ NO
10. Have you ever had kidney stones? ☐ YES ☐ NO
11. Have you ever been treated with radiation for any medical conditions? ☐ YES ☐ NO

    If yes, which medical condition? _____
12. Have you ever had an internal abdominal or heart infection? ☐ YES ☐ NO

    If yes, which? _____
13. Do you have any oral surgery planned in the next 12 months? ☐ YES ☐ NO
14. What medications have you taken for osteoporosis, and have you had any reactions to those medications?:

    Medication:

    A. _____ Reaction: _____

    B. _____ Reaction: _____

    C. _____ Reaction: _____