PRECISION ENDOCRINOLOGY

Patient's Name (First, Middle, Last): _____ Address: _____

City:_____State:_____Zip Code:_____Email:_____

Main Contact#:_____Alternate#:_____Work#: _____

Date of Birth:_____/_____/_____ Sex: ○ Male ○ Female SS# (optional): _____

Marital Status : ○Single ○Married ○Divorced ○Widowed Occupation: _____

Patient Referred By:_____Spouse's Name: _____

Spouse's Date of Birth:_____/_____/_____ Main Contact#: _____ Alternate#: _____

Emergency Contact:_____Relationship:_____Phone#: _____

Primary Care Physician:_____Phone#:_____

Referring Physician:_____Phone#:_____

Insurance Information

Primary Insurance:_____Policy/ID# _____

Name of Policy Holder:_____DOB:_____ /____/_____Group/Acct #:_____

Employer:_____Employer Address: _____

City: _____ State: _____ Zip Code:_____Work #: _____

Secondary Insurance:_____Policy/ID#: _____

Name of Policy Holder:_____DOB:_____ /____/_____Group/Acct #:_____

Employer:_____Employer Address: _____

City: _____ State: _____ Zip Code:_____Work #: _____

Complete – Only if Patient is a Minor

Father's/Guardian Name:_____Relationship: _____

Mother's/Guardian Name:_____Relationship: _____

Siblings:_____DOB:_____ /____/_____Other Siblings:_____DOB:_____ /____/_____

PRECISION ENDOCRINOLOGY

NEW PATIENT MEDICAL HISTORY FORM

DATE : _____

NAME:_____**D.O.B.**____ /_____/_____

LAST FIRST MI

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

REFERRING PHYSICIAN:

Daytime Phone #:_____Alternate Phone #: _____

Email address *(optional):* _____

Can we contact you at this address for medical issues? ❑ Yes ❑ No

Ethnicity: ❑ Hispanic ❑ Non Hispanic

Race: ❑ Caucasian ❑ Black ❑ Native American
❑ Asian ❑ Indian ❑ Other _____

ALLERGIES (Include medications, foods, x-ray dyes) or circle **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		
4		
5		

CURRENT MEDICATIONS Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or circle **NONE** if you are not taking any medication

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				
4				
5				

6				
7				
8				
9				
10				

PHARMACY (List preferred Pharmacy or list pharmacy most frequently used for prescriptions)

Name:_____

Phone #:_____ Fax #: _____

Address:_____ City:_____ State/Zip:_____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or circle **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

MEDICAL HISTORY

1.	**4.**	**7.**
2.	**5.**	**8.**
3.	**6.**	**9.**

DRUG ALLERGIES

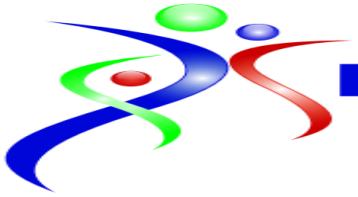
1.	**3.**	**5.**
2.	**4.**	**6.**

HOSPITALIZATIONS

Hospital Name	Reason for Hospitalization	Date/Year

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or circle **NONE** if no surgeries

Type of surgery	Hospital or city if known	Date/Year



PRECISION ENDOCRINOLOGY

OB/GYN HISTORY:

No of Pregnancies :

Last Menstrual Period :

SOCIAL HISTORY

Martial Status: Married ❑ Single ❑ Divorced ❑ Widowed

Do you smoke? ❑ Yes ❑ No ❑ Quit

If yes: How many cigs a day?_____for how long? _____

If quit: when did you quit? _____

When you did smoke, how many cigs a day?_____for how long? _____

Do you exercise? ❑ Yes ❑ No

Times per week?:_____

Do you drink alcohol? ❑ No ❑ Yes drinks per ❑ Day ❑ Week ❑ Month

Do you consume caffeine? ❑ No ❑ Yes, drinks per ❑ Day ❑ Week ❑ Month

Do you currently use recreational drugs? ❑ Yes ❑ No

Have you used recreational drugs in the past? ❑ Yes ❑ No

FAMILY HISTORY - are you Adopted?	❑ Yes	❑ No

Has any of your family members had any of the following?

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age								
Diabetes								
Hypertension								
High Cholesterol								
Cancer								
Heart Disease								
Thyroid Disease								

PRECISION ENDOCRINOLOGY

NEW PATIENT
MEDICAL HISTORY FORM

ODAY: _____

NAME: _____ **D.O.B.** __/__/_____
FIRST M.I. LAST

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	Fatigue / Tired	☐Yes	☐No
	Fever / Chills	☐Yes	☐No
	Headache	☐Yes	☐No
	Weight Loss	☐Yes	☐No
	Weight Gain	☐Yes	☐No
Eyes	Difficulty Seeing	☐Yes	☐No
	Other: _____		
Head Ears Nose Throat	Dry Mouth	☐Yes	☐No
	Hearing Problems	☐Yes	☐No
	Hoarseness	☐Yes	☐No
	Lumps/Swelling in Neck	☐Yes	☐No
	Sore Throat	☐Yes	☐No
	Trouble Swallowing	☐Yes	☐No
	Other: _____		
Cardiac (Heart)	Chest Pain	☐Yes	☐No
	Irregular Heart Beat	☐Yes	☐No
	Pain with Walking	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Swelling in Feet/Ankles	☐Yes	☐No
	Other: _____		
Neuro	Dizziness	☐Yes	☐No
	Fainting	☐Yes	☐No
	Headache	☐Yes	☐No
	Memory Loss	☐Yes	☐No
	Numbness	☐Yes	☐No
	Weakness	☐Yes	☐No
	Other: _____		
Respiratory	Cough	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Use of Inhalers	☐Yes	☐No
	Wheezing	☐Yes	☐No
		☐	☐
Gastro-Intestinal	Abdominal Pain	☐Yes	☐No
	Blood in Stool	☐Yes	☐No
	Change in BowelHabits	☐Yes	☐No
	Constipation	☐Yes	☐No
	Heartburn	☐Yes	☐No
	Loss of Appetite	☐Yes	☐No
	Nausea	☐Yes	☐No
	Vomiting	Yes	No
	Other: _____		

Males Only	Blood in Urine	☐Yes	☐No
	Difficulty Achieving Erection	☐Yes	☐No
	Foul Odor in Urine	☐Yes	☐No
	Pain in Testicles	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
Females Only	Breast Discomfort	☐Yes	☐No
	Irregular Bleeding	☐Yes	☐No
	Last Menstrual Cycle *Date*		
	Painful Intercourse	☐Yes	☐No
	Post Menopausal Bleeding	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Vaginal Discharge	☐Yes	☐No
Musculoskeletal			
	Back Pain	☐Yes	☐No
	Joint Pain	☐Yes	☐No
	Muscle Pain	☐Yes	☐No
	Swelling	☐Yes	☐No
	Other: _____		
Skin Hair Nails	Bruising	☐Yes	☐No
	Hair Loss	☐Yes	☐No
	Nail Problems	☐Yes	☐No
	Rash	☐Yes	☐No
	Skin Changes	☐Yes	☐No
	Other: _____		
Mental Health	Anxiety	☐Yes	☐No
	Depression	☐Yes	☐No
	Difficulty Sleeping/Concentrating	☐Yes	☐No
	History of Physical/Mental Abuse	☐Yes	☐No
	Mood Swings	☐Yes	☐No
	Stress	☐Yes	☐No
	Suicidal	☐Yes	☐No

Recent Tests/ Health Maintenance (Give month/year of last exam in right column. Check left column if date is estimated.)

- ☐ Bone Density: _____
- ☐ Diabetic Foot Exam: _____
- ☐ Eye Exam: _____
- ☐ Mammogram: _____
- ☐ Physical: _____
- ☐ PSA: _____
- ☐ Tetanus Shot: _____