marinhealth Medical Network | UCSF Health

ENDOCRINE & DIABETES CARE

HEALTH HISTORY

Today's Date: _____

Full Name: _____ **Date of Birth:** _____ **Age:** _____

Primary Care Physician: _____

Other Specialists You See: _____

What medical problems would you like to discuss today? _____

_____

_____

Circle any conditions that apply:

Abnormal Bleeding	Adrenal Disease	Arthritis	Blood Clots	Calcium Disorder
Cancer	Diabetes	Eye Disease	Foot Ulcers	Heart Disease
High Blood Pressure	High Cholesterol	Irregular Heartbeat	Kidney Disease	Neuropathy
Obesity	Parathyroid Disease	Stomach Ulcers	Stroke	Thyroid Disease

List any additional medical problems and/or hospitalizations:

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

List any surgeries you have had including the month/year and where they were performed:

1. _____
2. _____
3. _____

List your most recent medication list (including herbal supplements and over the counter medications):

Medication	Dose	Frequency

Are you allergic to contrast (x-ray dye) or shell fish? Yes No

Do you have any known drug allergies? Yes No

If yes, list below:

Medication Allergy	Reaction

Have you ever been a smoker? Yes No

If yes, at what age did you start? _____

At what age did you stop (if you have)? _____

How many packs per day did/do you smoke? _____

Do you drink alcohol regularly? Yes No

If yes, how much daily? _____

Do you think you may have a problem with drinking? Yes No

Are you currently working? Yes No

What is your occupation? _____

Do you exercise daily? Yes No

What do you do for exercise? _____

Do you follow any of these diets (circle all that apply)?

Low Calorie Low Cholesterol Low Salt

Briefly describe your usual diet: _____

_____

What was your weight at the following ages:

18-20 _____ 35-40 _____ Current _____

Have you participated in any diet programs? Yes No

If yes, please describe: _____

_____

Family History

Family Member (circle M or F)	**Age Living or Age at Death**	**List any of these medical conditions that apply:** Diabetes type 1 or type 2, Thyroid Disease, Thyroid Cancer, Osteoporosis, Hyperparathyroidism, High Cholesterol, Obesity
Mother		
Father		
Siblings 1 - M or F		
2 - M or F		
3 - M or F		
4 - M or F		
Offspring 1 - M or F		
2 - M or F		
3 - M or F		
4 - M or F		

Check YES or NO if you currently have or have had the following conditions:

EYES	No	Yes
Blurry Vision		
Double Vision		
Glaucoma		
Cataracts		
Retinopathy		
Macular Degeneration		
Red Eyes		
Loss Peripheral Vision		
Last Eye Exam:		
EARS, NOSE & THROAT		
Ear Pain/Pressure		
Sinus Problems		
Mouth Sores		
Hearing Loss		
Tinnitus		
Difficulty Smelling		
Dental Problems		
PULMONARY		
Wheezing		
Persistent Cough		
Cough up Blood		
Shortness of Breath		
Recurrent Bronchitis		
Sleep Apnea		
Snoring		
Emphysema		
TB Exposure		
CARDIOVASCULAR		
Chest Tightness		
Irregular Heartbeat		
Heart Palpitations		
High Blood Pressure		
Low Blood Pressure		
Heart Murmur		
Claudication		

GASTROINTESTINAL	No	Yes
Indigestion		
Heartburn/ GERD		
Nausea/Vomiting		
Hiatal Hernia		
Gallbladder		
Loss of Appetite		
Abdominal Pain		
Diarrhea		
Constipation		
Dark Stool		
Rectal Pain		
Hemorrhoids		
Peptic Ulcer		
Trouble Swallowing		
Weight Loss		
Weight Gain		
URINARY TRACT		
Kidney Problems		
Bladder Problems		
Recurrent UTI		
Kidney Stones		
Painful Urination		
Incontinence		
Urinate at Night		
MUSCLE/JOINTS		
Arthritis		
Neck Pain		
Joint Pain/Swelling		
Morning Stiffness		
Bursitis		
Muscle Aches		
Back Pain		
Blood Clots		

NEUROLOGICAL	No	Yes
Headache/Migraine		
Convulsion/Seizures		
Tremors		
Numbness		
Tingling		
Stroke/ TIA		
Fainting		
Vertigo/Dizziness		
Difficulty Walking		
PSYCHOLOGICAL		
Memory Loss		
Depression		
Anxiety/Panic		
Irritability		
Bulimia		
Anorexia		
SKIN		
Acne		
Easy Bruising		
Poor Wound Healing		
Change of Skin Color		
Stretch Marks		
Dry Skin		
Change in Hair		
Change in Nails		
GENERAL		
Anemia		
Transfusions		
Fatigue		
Weakness		
Change in Libido		

EXPANDED ENDOCRINE SYMPTOM REVIEW

Date diagnosed with Diabetes: _____ Type 1 or 2: _____

Circle Symptoms:

Increased Thirst	Dry Mouth	Increased Urination	Diarrhea
Blurred Vision	Low Blood Sugars	Pain/Tingling in Extremities	Diabetic Eye Disease
Diabetic Kidney Disease	Chronic Foot Ulcers	Chronic Foot Infections	Laser Photocoagulation

More Details/Other: _____

_____

Date of Last Eye Exam: _____ Ophthalmologist: _____

Date of Last Foot Exam: _____ Podiatrist: _____

Thyroid (circle all that apply):

Fatigue	Feeling Cold	Tremors	Racing Heart
Palpitations	Trouble Swallowing	Neck Swelling/Pain	Change in Voice
Hoarseness	Change in Hair	Change in Nails	Change in Skin
Constipation	Excessive Sweating	Insomnia	Anxiety
Weight Loss/Gain	History of Head/Neck Radiation		

Osteoporosis (circle all that apply):

Height Loss	Current Smoker	Vitamin D Deficiency	Steroid Use
Lactose Intolerance	Malabsorption	Celiac Disease (Gluten)	Flushing
Anticonvulsants	Alcohol: >3 drinks per day	Low Body Weight	Eating Disorder

Family History of Osteoporosis History of Fractures (age, type): _____

WOMEN'S Endocrine Menstrual History/GYN

Age of onset: _____ Are your menses regular? Yes No Date of last period: _____

Number of Pregnancies: _____ Number of Births: _____ Breastfeeding? Yes No

Age at Menopause: _____ Hysterectomy? Yes No If yes, at what age? _____

Past /Present Hormone Replacement Therapy:_____

_____

Other Symptoms (circle all that apply): Hot flashes/Night Sweats Change in Libido

Vaginal Dryness Breast Discharge Excessive Hair Growth Not Sexually Active

MEN'S Endocrine (circle all that apply):

Change in Libido Erectile Dysfunction Change in Hair/Beard Growth

Pituitary (circle all that apply): Vision Changes Headache Muscle Weakness

Changes in Pigmentation History of Pituitary Tumors

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to anyone except when you have authorized us to do so or by a court order. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the office of any changes in my (or my child's) medical status. I also authorize Marin Endocrine Center healthcare staff to perform the necessary health services that I (or my child) may need.

PATIENT'S SIGNATURE_____

GUARDIAN'S SIGNATURE (if under 18) _____

PHYSICIAN'S SIGNATURE _____

Marin Endocrine Care and Research is actively engaged in new and practical research in many areas of endocrinology and metabolism with the purpose of incorporating leading edge pharmaceutical advances into our community based practice. Please let us know if you would be interested in participating in endocrine related research studies conducted by our physicians.

☐ No, I am not interested.

☐ Yes, please notify me about any clinical studies I may qualify for:

Name (Print): _____ **Signature:** _____

Date: _____ **Email Address:** _____