Mary Washington Endocrinology

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Medical History

Name:_____ Date of Birth: _____/ _____ / _____
Last First Middle Inital Madden Month Day Year

Primary Physician:_____ Referring Physician: _____

Reason for Visit: _____

Preferred Retail Pharmacy & Location: _____

Preferred Mail Order Pharmacy: _____

Social History

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Highest Level of Education: _____ Occupation:_____

Employment Status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled

Employer: _____

Please check all problems that apply to your medical history:

	Adrenal Problems		Diverticulitis		Hyperthyroid
	Alcohol Abuse/ Addiction		Drug Abuse/ Addiction		Kidney Disease
	Anemia/ Low blood count		Epilepsy/ Seizure		Kidney Stone
	Anxiety		Gall bladder Disease		Liver Disease
	Arthritis		Eye issues: _____		Lung Disease
	Asthma		Gout		Menstruation Problems
	Bladder Disease		Hay fever/ Seasonal allergies		Migraine Headaches
	Bleeding tendency		Hearing Problems		Pneumonia
	Blood Disorders		Heart Disease/ Attack		Pituitary Problems
	Bowel Problems		Hemorrhoids		Rheumatic Fever
	Bronchitis		Hepatitis		Skin Disease
	Cancer		Hereditary Defect		Thyroid Cancer
	Calcium Problems		Hernia		Tuberculosis (TB)
	Depression		High Blood Pressure		Ulcers
	Diabetes – Type 1 or Type 2		Hyperparathyroidism		Other:_____
	DIABETES EDUCATION?		Hypothyroid		Other:_____

Gynecologic and Obstetric History, if applicable:

Menstrual Cycle:

Age of onset: _____ First day of last cycle: _____

Frequency: _____ Heavy bleeding: ❑ YES ❑ NO

Length: _____ Excessive bleeding: ❑ YES ❑ NO

Have you had menopause? ❑ YES ❑ NO Year: _____

Number of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Are you allergic to anything, especially any medications?

Medication	Type of Reaction

Hospitalizations **Surgeries**

Year	Reason	Year	Reason

Smoking or Vaping Status: ❑ Never ❑ Chew ❑ Previously, but quit ❑ Currently _____packs/day

Do you drink alcohol? ❑ YES ❑ NO How much?: _____

Do you use street drugs? ❑ Never ❑ Chew ❑ Previously, but quit ❑ Drug type: _____

Family History

	Alive		Deceased	
	Age	Present Health/Health Problems	Age at Death	Cause of Death
Father				
Mother				

	Number Living	Present Health/Health Problems	Number Deceased	Cause of Death
Brothers				
Sisters				
Children				

Other Significant Family History

_____

_____

_____

_____

Medication

Full Name: _____ Date of Birth: _____

Medication	Dose	Directions

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Full Name: _____ Date of Birth: _____

New Patient Review of Systems

Please CIRCLE if you CURRENTLY are having or RECENTLY have had any of the symptoms listed below:

General	Fevers, fatigue, chills, anorexia, unintentional weight gain (how many pounds? ____ over what period of time? _____), unintentional weight loss (how many pounds? ____ over what period of time? _____)
Head / Face	Facial pain or pressure
Eyes	Redness of the eyes, watering of the eyes, itching eyes, blurred vision, double vision, loss of vision
Nose/ Throat	Earache, loss of hearing, decreased hearing, nasal congestion, sore throat, hoarseness of voice, difficulty with swallowing (does this occur with solids, liquids, or both?) Pain over the thyroid gland, new lumps or bumps over the thyroid gland
Cardiovascular	Chest pain, palpitations, racing heart, lightheadedness, swelling in the legs
Lungs	Shortness of breath at rest, shortness of breath with activity, cough
Gastrointestinal	Abdominal pain, abdominal bloating, nausea, vomiting, diarrhea, constipation, blood in stools
Genitourinary	Burning with urination, increased urinary frequency, increased urinary urgency, blood in the urine
Musculoskeletal	Joint pain, generalized muscle aches, back pain, falls
Skin	New rashes, wounds or lesions. Generalized skin itching, yellowing of the skin
Neurological	Frequent headaches, dizziness, fainting, numbness, tingling, weakness just on one side of the body
Psychiatric	Insomnia (Do you have difficulty falling asleep or staying asleep?), worsened anxiety, irritability, depression
Endocrine	Urinating a lot, feeling thirsty all of the time, hot flashes, night sweats, tremors, heat intolerance, cold intolerance, excessive sweating, brittle hair, brittle nails
Hematologic/ lymphatic	Swollen glands, swollen glands in the neck, easy bleeding, easy bruising, jaundice
Reproductive	Lack of sex drive, difficulty with erection, heavy menstrual flow, absent of decreased frequency of menstruation