AdventHealth
Medical Group

Endocrinology and Diabetes
Patient History Questionnaire

Name:_____Age:_____DOB: _____
Date form completed:_____Referred by: _____
Primary Care Provider: _____
Reason for visit: _____
Medication allergies: _____
Medications you cannot tolerate: _____

Current medications including vitamins and supplements:

Name	Dose

Medical diagnoses and surgeries:

Personal History

Occupation:_____
Tobacco use:_____How many per day? _____
Alcohol per week: _____

PATIENT HISTORY QUESTIONNAIRE

Current Issues (mark all that apply):

_____ Fatigue
_____ Weight loss
_____ Weight gain
_____ Insomnia

_____ Vision loss
_____ Eye pain

_____ Swallowing difficulty
_____ Hoarseness
_____ Mouth sores

_____ Cough
_____ Shortness of breath

_____ Chest pain
_____ Swelling
_____ Palpitations

_____ Constipation
_____ Diarrhea
_____ Frequent nausea

_____ Burning with urination
_____ Urinating frequently
_____ History of kidney stones

_____ Hair loss
_____ Dry skin
_____ Nail changes
_____ Skin ulcer
_____ Rash
_____ Hair growth in undesired places

_____ Breast tenderness
_____ Breast discharge

_____ Back pain
_____ Joint pain
_____ Muscle weakness

_____ Headaches
_____ Memory loss
_____ Numbness or tingling in extremities
_____ Tremors/shaking in hands

_____ Anxiety
_____ Depression

_____ Intolerance to cold
_____ Intolerance to heat
_____ Excessive sweating
_____ Goiter
_____ Hypoglycemia if diabetic
_____ Increased thirst

_____ Lymphadenopathy
_____ Low blood counts

_____ Hives
_____ Angioedema

For Women Only:
_____ Irregular periods
_____ Planning future pregnancies
_____ History of infertility
_____ Sexual difficulty

For Men Only:
_____ Decreased libido
_____ Erectile dysfunction

Family History

Mother's medical problems: _____

Father's medical problems: _____

Family history of the following:

_____Diabetes
_____Thyroid disease
_____Adrenal or pituitary issue
_____Cancer (include type)
_____Osteoporosis

Any other history that you feel would be useful to be considered:

_____

_____

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