MARK A. LUPO, M.D.
THYROID & ENDOCRINE CENTER OF FLORIDA

Mark A. Lupo, M.D., F.A.C.E., E.C.N.U.
Board Certified in Endocrinology

Zsofia Geck, M.D.
Board Certified in Endocrinology

PATIENT HEALTH HISTORY

Welcome to our practice! Please answer the questions as they relate to the person being evaluated. Bring this completed form to your first appointment, along with your insurance card.

Patient Name: _____ Patient Age / Birth Date: _____

Primary Care Physician: _____

Whom may we thank for your visit? _____

For what health concerns are you coming to see us? _____

_____

List medications (including over-the-counter, nutritional supplements and vitamins) with doses and frequency.

PLEASE ATTACH A SEPARATE SHEET FOR 5 OR MORE MEDICATIONS. _____

_____

_____

Please list medication allergies: _____

Please check if you have <u>ever</u> had any of these conditions:

☐ Underactive Thyroid ☐ Overactive Thyroid ☐ Enlarged Thyroid ☐ Thyroid Nodules ☐ Thyroid Cancer

☐ Heart Attack ☐ Heart Failure ☐ High Cholesterol ☐ Stroke ☐ Heart Rhythm Problem ☐ Heart Valve Problem ☐ Hypertension

☐ Parathyroid Disease ☐ Abnormal Blood Calcium ☐ Bone Fracture ☐ Lung Disease

☐ Depression ☐ Anxiety ☐ Sleep Apnea ☐ Blood Disorder or Anemia ☐ Kidney Disease ☐ High Cholesterol

☐ Fibromyalgia ☐ Arthritis ☐ Sjogren's Syndrome ☐ Lupus ☐ Infertility ☐ Miscarriages

☐ Liver Disease ☐ Heartburn ☐ Stomach Ulcer ☐ Intestinal Disease ☐ Diabetes

☐ Cancer & type: _____ Treatments: _____

☐ Other

Conditions:_____

Reproductive History (women only): Regular Cycles? - ☐ yes ☐ no Number of Pregnancies _____

Live Deliveries _____ Last Menstrual Period _____ Age of Menopause _____

Have you ever had a thyroid biopsy (FNA)? If so, when/where and what were results?

_____

Have you had x-rays of your thyroid or neck (including ultrasound, nuclear scans and CT scans)? If so, bring reports.

_____

Have you ever had a kidney stone? How many times? When was the last kidney stone?

_____

Do you have Osteoporosis or Osteopenia (thin bones)? Have you had a bone density test? If so, bring report.

_____

Do you have a history of pituitary or adrenal problems? If so, explain.

_____

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Have you ever had radiation treatment involving your neck or been given radioactive iodine treatment for your thyroid?

_____

Have you ever had any surgery on your neck? If so, list type and date:

_____

Please list any other surgeries, including year and reason:

_____

_____

Social and Family History

Are you… ☐**Single** ☐**Married** ☐**Separated** ☐**Divorced** ☐**Widowed**

Do you use tobacco in any form? _____ Type? _____ Amount?_____ IF Quit, When? _____

Do you drink alcohol?_____ Type?_____ Amount?_____

Do you exercise? _____ Type? _____ Amount? _____min **Frequency? _____** times per week**.**

Occupation (Present or former if retired) _____

Please tell us about your family's health history (include age or age at death, diseases or cause of death).

☐ Father: _____ ☐ Mother: _____

☐ Siblings: _____☐ Children:_____

Do any of the following run in your family? ☐ Thyroid Problems ☐ Thyroid Cancer ☐ Parathyroid Disease ☐ Heart Attacks ☐ Osteoporosis ☐ Stroke ☐ Diabetes ☐ Auto-Immune Disease (such as Lupus) ☐ Pituitary or Adrenal Disease ☐ Kidney Stones

Please check symptoms which you are <u>currently</u> experiencing:

General: ☐Chills ☐Fatigue ☐Fever ☐Weight loss (amount:_____) ☐*Drenching* night sweats ☐Tight rings/shoes ☐Easy bruising ☐Loss of height ☐ Weight gain (amount_____)

ENT: ☐Headache that is out of ordinary for you ☐Snoring ☐Hoarseness

Eyes: ☐Aching ☐Watery ☐Swollen ☐Dry ☐Redness ☐Double vision ☐Vision problems

Skin: ☐Itching ☐Dryness ☐Rashes ☐Hives ☐Unwanted hair ☐Brittle nails ☐Cracking skin ☐Hair Loss

Respiratory: ☐Cough ☐Shortness of breath ☐Wheeze ☐Choking sensation

Cardiac: ☐Chest pain ☐High blood pressure ☐Irregular heart beat ☐Fainting

Intestinal: ☐Vomiting ☐Constipation ☐Diarrhea ☐Indigestion ☐Nausea ☐Abdominal pain ☐ Trouble swallowing

Endocrine: ☐Excessive thirst ☐Significant sensitivity to heat ☐Significant sensitivity to cold ☐ Shakiness

Muscle-Joint: ☐Joint pain ☐Ankle or leg swelling ☐Muscle pain ☐Muscle weakness ☐ Exercise intolerance

Neurological: ☐Numbness/Tingling ☐Seizures ☐ Dizziness ☐ Vertigo ☐ Flushing sensations ☐Tremor

Urinary: ☐Burning ☐Pain ☐Frequency ☐Large amounts of urine ☐Blood in urine

Women only: ☐Irregular periods ☐Pregnant ☐Trying to get pregnant

Psychological: ☐Insomnia ☐Depression ☐Nervousness ☐Difficulty concentrating ☐Mood Swings

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Is there any other information that you would like for us to know?

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient *Date* **S***ignature of Staff Reviewer / Physician* *Date*