

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 ever 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.

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 currently 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

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

Signature of Staff Reviewer / Physician

Date