CENTRAL VALLEY ENDOCRINOLOGY, PC
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MEDICAL HISTORY QUESTIONNAIRE FORM

DATE: ____/_____/____

NAME: _____

AGE: _____ HEIGHT:_____ WT:_____

INITIAL HISTORY

1. WHY ARE YOU COMING TO THE DOCTOR? _____
_____

2. REFERRING PHYSICIAN? _____

3. HAVE YOU EVER HAD ANY OF THE FOLLOWING (Please check)?

○ DIABETES ○ HIGH CHOLESTEROL ○ HIGH BLOOD PRESSURE ○ STROKE
○ HEART ATTACK ○ ANGINA ○ THYROID PROBLEMS ○ HISTORY OF RADIATION
○ CANCER (specify:_____) ○ OTHERS_____

3. LIST ANY SURGERIES THAT YOU HAVE HAD:

SURGERY: _____ YEAR: _____

SURGERY: _____ YEAR: _____

SURGERY: _____ YEAR: _____

4. LIST ANY PAST HOSPITALIZATIONS:

WHEN:_____ WHY: _____

WHEN: _____ WHY:_____

5. WHAT MEDICATIONS ARE YOU TAKING (If Diabetic, see Diabetes Questionnaire)?

MEDICATION_____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE _____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE _____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____

6. ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, WHICH ONES? _____

_____

7. FAMILY HISTORY:
A) DO YOU HAVE FAMILY MEMBERS WITH DIABETES? YES NO

IF YES, WHO HAS DIABETES? _____

B) DO YOU HAVE FAMILY MEMBERS WITH A THYROID PROBLEM? YES NO

IF YES, WHO HAS THYROID PROBLEM?_____

C) PLEASE CHECK IF **BLOOD RELATED** MEMBERS OF YOUR FAMILY HAVE HAD ANY OF THE FOLLOWING:

_____ HEART DISEASE _____ HIGH BLOOD PRESSURE _____ OBESITY

_____STROKE _____ HIGH CHOLESTEROL _____ HIGH BLOOD PRESSURE

_____ MENSTRUAL PROBLEM _____ PROSTRATE CANCER _____ BREAST CANCER

_____ ADRENAL PROBLEM _____ PITUITARY PROBLEM _____ BONE PROBLEM

8. IMMUNIZATION: WHEN

FLU SHOT _____

PNEUMO VACC _____

9. SOCIAL HISTORY:

10.

MARITAL STATUS: Single Married Divorced Separated Widowed

DO YOU SMOKE CIGARETTES ?_____ HOW MANY PACKS /DAY?_____

DO YOU DRINK ALCOHOL ?_____HOW MANY PER DAY/WEEK?_____

EDUCATION COMPLETED ? GRADE SCHOOL____ HIGH SCHOOL___ COLLEGE_____

ANY HISTORY OF ILLICIT DRUG USE ?

10. CURRENT SYMPTOMS (Review of Systems):

General:

Weight Gain	YES OR NO (How much? _____)
Weight Loss	YES OR NO (How much? _____)
Weakness	YES OR NO
Fatigue	YES OR NO

Skin:

Hair Loss	YES OR NO
Itching	YES OR NO
Dryness	YES OR NO

Eyes, Ear, Nose & Throat:

Blurred vision (recent)	YES OR NO
Cataract	YES OR NO
Laser Treatment (not LASIK)	YES OR NO (when? _____)

Chest:

Cough	YES OR NO
Shortness of breath	YES OR NO

Cardiovascular:

Chest pain	YES OR NO
Palpitations	YES OR NO
Shortness of breath with exertion	YES OR NO
Shortness of breath while lying flat	YES OR NO
Swelling of the legs/ ankles	YES OR NO
Painful legs while walking	YES OR NO
Foot ulcers	YES OR NO

Gastrointestinal:

Loss of appetite	YES OR NO
Excessive hunger	YES OR NO
Heartburn	YES OR NO
Nausea	YES OR NO
Abdominal pain	YES OR NO
Constipation	YES OR NO
Loose bowel movements (diarrhea)	YES OR NO

Urinary:

Frequent urination	YES OR NO
Problem starting stream	YES OR NO
Incontinence	YES OR NO

Genital:

Libido (desire) Normal or Low

Men:

Erection problems YES OR NO

Women:

Regular periods YES OR NO

No. of pregnancies: _____

Menopause YES OR NO (age at menopause:_____)

If yes: natural or surgical

Age, periods started: _____

Last menstrual period: _____

Musculoskeletal:

Arthritis YES OR NO

If yes: what joints bother you the most: _____

Tendonitis/ Bursitis YES OR NO

Back or neck pain YES OR NO

Neurological:

Frequent headaches	YES OR NO
Burning sensation in the feet & hands	YES OR NO
Numbness in the feet & hands	YES OR NO
Depressed	YES OR NO
Mood swings	YES OR NO

IF YOU ARE SEEING Dr. SAHASRANAM FOR DIABETES, PLEASE FILL OUT THE DIABETES FIRST QUESTIONNAIRE AS WELL

_____ _____

Patient Signature Date

_____ _____

Prem Sahasranam, M.D. (Reviewed with the patient) Date