

DIABETES AND ENDOCRINOLOGY CONSULTANTS

HEALTH HISTORY

Rashid A. Khairi, M.D. / Demetrios T. Herodotou, M.D. /
D. Anthony Lee, M.D. / Ernest O. Asamoah, M.D.

Pt. Acct #: _____

Name: _____ D.O.B: _____ Age: _____

Referred By: Self _____ Physician _____ Friend _____ Other _____

CHIEF COMPLAINT:

CURRENT MEDICATIONS: Please list

Medication	Strength	Frequency	Medication	Strength	Frequency

ALLERGIES: Please List

FAMILY HISTORY:

Check the appropriate space if any family members have or have had the following, specify which member:

() Obesity _____ () Stroke _____
() Diabetes _____ () Heart disease _____
() High blood pressure _____ () Arthritis _____
() Cancer _____ () Thyroid _____

SOCIAL HISTORY:

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Please list children and their ages:

Do you smoke?	If yes, how much?
How much alcohol do you drink in one week?	
What is our occupation?	
Any dangerous environmental exposures?	
Do you have a regular exercise routine?	Explain:

PAST MEDICAL HISTORY: Please list any surgeries, Medical Illness, including hospitalizations:

Reason	Date	Where

Continued on other side.....

MENSTRUAL HISTORY:

Last Menstrual period	_____	Duration	_____
Cycle length	_____	Age of onset	_____
# of pregnancies	_____	# of miscarriages	_____
Cramps	_____	Hormone therapy?	_____

Please check the appropriate box if you have or have had any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Constipation / diarrhea	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sexual dysfunction
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Coronary / heart disease	<input type="checkbox"/> Indigestion / heart burn	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Asthma / lung disease	<input type="checkbox"/> Daytime drowsiness	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Skin lesions
<input type="checkbox"/> Back pain	<input type="checkbox"/> Depression / anxiety	<input type="checkbox"/> Irregular/Rapid heart beat	<input type="checkbox"/> Stroke
<input type="checkbox"/> Back pain	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint pain / swelling	<input type="checkbox"/> Swelling on the neck
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood in sputum	<input type="checkbox"/> Excessive hair loss	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Ulcer disease
<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Fainting	<input type="checkbox"/> Leg ankle edema (swelling)	<input type="checkbox"/> Urinary problems
<input type="checkbox"/> Bowel disease	<input type="checkbox"/> Gall bladder disease	<input type="checkbox"/> Nausea / vomiting	<input type="checkbox"/> Vision changes
<input type="checkbox"/> Calf tenderness	<input type="checkbox"/> Gout	<input type="checkbox"/> Painful or difficult swallowing	<input type="checkbox"/> Weakness in arms and legs
<input type="checkbox"/> Cancer	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychiatric illness	<input type="checkbox"/> Other: explain below
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Respiratory problems	

Please explain in full any check marks above:

ADDITIONAL COMMENTS:

Patient Signature: _____

Today's Date: _____