



Albemarle Endocrinology, PLC  
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## New Patient History Form

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Please complete this form and bring it with you when you come to the office. Thank you.

Reason for coming:

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**PAST MEDICAL HISTORY:** Have you ever had any of the following illnesses?

Please circle and state **year of onset**

Alcoholism	Colitis	High cholesterol	Prostate disease
Addiction	Depression	High blood pressure	Seizures
Anemia	Diabetes	Hives/eczema	Thyroid disease
Angina	Gallbladder disease	Kidney disease	Tuberculosis
Arthritis	Glaucoma	Migraines	Ulcers
Asthma/hay fever	Gout	Osteoporosis	Urinary infections
Blood transfusions	Heart problems	Pancreatitis	
Cancer of:	Hepatitis	Pneumonia	
Other:			

**HOSPITALIZATIONS:** Were you ever hospitalized for operations, illness, or injury?

Reason/Year

Reason/Year


**MEDICATIONS:** List current medications and dosage, including over the counter medications and supplements:

Medication      Dose              Frequency              Medication              Dose              Frequency


**ALLERGIES:** Allergy to any drug \_\_\_\_\_

X-Ray Dye \_\_\_\_\_ Food \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart No: \_\_\_\_\_

**RECENT PROBLEM LIST**

Have you had problems with any of the following?

Symptom	Yes	No	Symptom	Yes	No
fatigue			<b>FOR WOMEN ONLY:</b>		
loss of energy			unusual vaginal bleeding		
weight gain			low sexual desire		
weight loss			irregular menstrual cycle		
increase in appetite			change in menstrual cycle		
decrease in appetite					
excessive thirst			<b>FOR MEN ONLY:</b>		
feeling excessively cold			low sexual desire		
feeling excessively hot			difficulty with erections		
excessive sweating			pain in testicles		
poor sleep			lump in testicles		
fever					
			muscle aches		
blurred vision			muscle weakness		
double vision			joint aches		
loss of vision			joint stiffness		
loss of peripheral vision			gout		
loss of hearing			change in ring size		
stuffy or runny nose			change in shoe size		
sinus Problems			dentures no longer fit (if pertinent)		
dry mouth					
sore throat					
persistent hoarseness			headaches		
swollen glands in neck			difficulty with concentration		
neck fullness			fainting		
choking sensation			blackouts/loss of consciousness		
pressure in the neck			seizures		
			paralysis		
chest pain			numbness or tingling		
heart racing					
palpitations			skin rash		
swelling in feet or legs			dry skin		
			itching		
cough					
wheezing			breast tenderness		
shortness of breath			fluid leakage from breast		
			breast lump		
nausea					
vomiting			depressed mood		
trouble swallowing			loss of interest or pleasure in doing things		
heartburn			excessive nervousness		
abdominal pain			anxiety attacks		
diarrhea					
constipation					
change in bowel movements			excessive hair growth		
excessive urination			hair loss or balding		
getting up to urinate at night			easy bruising or bleeding		

For Women Only:

How old were you when you had your first menstrual cycle? \_\_\_\_\_

What was the date of your last menstrual cycle? \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Chart No: \_\_\_\_\_

Have you gone through menopause? \_\_\_\_\_ No \_\_\_\_\_ Yes What age? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_

How many children have you had? \_\_\_\_\_

How many miscarriages have you had? \_\_\_\_\_

How many abortions have you had? \_\_\_\_\_

Do you currently use a method to prevent pregnancy? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, what method do you use? \_\_\_\_\_

When was your last mammogram? \_\_\_\_\_

**SOCIAL HISTORY:**

Habits: Do you smoke? Yes No Packs per day? \_\_\_\_\_

Past Smoking History Yes No Packs per day? \_\_\_\_\_ When stopped? \_\_\_\_\_

Do you drink alcoholic beverages? Yes No How much? \_\_\_\_\_  
(If you use illicit drugs, please speak to us in confidence.)

Do you exercise? Yes No How often? \_\_\_\_\_

Occupation: \_\_\_\_\_

Hobbies/Social activities: \_\_\_\_\_

Whom do you live with, if anyone? \_\_\_\_\_

Are you retired? \_\_\_\_\_ Are you now disabled? \_\_\_\_\_

**FAMILY HISTORY:** Has any member of your family (parents, brothers, sisters,) had any of the following?

Please circle who in the family. F=Father M=Mother S=Sibling

Diabetes	F	M	S
Heart disease	F	M	S
High blood pressure	F	M	S
Osteoporosis	F	M	S
Stroke	F	M	S
Thyroid Disease	F	M	S
Reproductive Difficulty	F	M	S
High Cholesterol	F	M	S
Obesity	F	M	S

Any family members with endocrine diagnosis or abnormalities, including diabetes, pituitary, adrenal, reproductive, metabolic and/or bone:

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