Syosset Endocrinology

Patient's Name: _____ **Age:** _____

Primary Care Physician: _____ **DOB:** _____

Health History

PLEASE PRINT

Past Medical History

Please list all medical problems and approximate dates of onset: (Example: Diabetes, Hypertension, Heart Disease, Thyroid Cancer, etc.)

_____

_____

Hospitalizations

Please list all hospitalizations, include dates and reasons, including surgeries:

_____

_____

Bone fractures and injuries

Please list all injuries such as bone fractures, etc:

Birthing and Menstrual History

Number of pregnancies: _____ **Number of live births:** _____
Age of each pregnancy: _____ **Weight of babies:** _____
Complications: _____

Age when period started: _____ **Date of last period:** _____
Frequency/ length of periods: _____ **Pain with periods:** _____
Hot flashes or sweats: _____

Psychiatric

Please list any history of depression, hospitalization for mental illness, suicidal thoughts?

_____

_____

Confidential

Syosset Endocrinology.

Patient's Name: _____

Review of Body Systems
(Please Print)

Weight- Have you gained or lost weight? _____
Height- Have you lost height? _____
General- Fatigue, fever, chills, tolerance of heat and cold? _____
Head- Headaches, loss of consciousness, dizziness? _____

Eyes- Vision change, eye pain or dry feelings, double vision, eye bulging? _____
_____

Mouth-Hoarseness, dental problems, bleeding after brushing?_____
_____

Nose- Bleeding, frequent sinus infectious?_____
_____

Neck-Stiffness, pain, swelling, goiter? _____

Breast- Masses, tenderness, nipple discharge?_____

_____
Last mammogram? _____ Where? _____

Chest- Pain, cough, bringing up blood, night sweats? _____
_____

Cardiac- **How far can you walk?_____**
Any chest pain or tightness?_____
Irregular heart beat?_____
How many pillows do you sleep on?_____
History of heart murmur or rheumatic fever? _____

Muscle/ Bone- Arthritis, joint pain or swelling, leg edema?_____
_____
Nerves- Problems with strength, balance, numbness, pain or needles and pins feelings in the extremities, tremor, falls, blackouts?_____
Skin- Rash, itching, jaundice, increased hair of body?_____
_____

Urinary- Problems with stopping or starting urine stream, pain with urination, history of urinary infections, prostrate problems, blood in urine, loss of control of urination?____
_____

Syosset Endocrinology

Patient's Name:_____

Review of Body Systems (cont)

(PLEASE PRINT)

Sexual- Male- Problems with potency or ejaculation?_____
_____
Female- Painful intercourse, problems with lubrication, vaginal discharge?_
_____

Medications- Include over the counter medications:

Name	Dosage	Date Started	For what condition

Allergies- Medicine_____
_____
Food_____
_____

Social History

Smoke _____ Packs/ Days For how long? _____ When did you quit?_____
Alcohol (indicate amount of intake per week): _____
Exercise: Type of exercise: _____
Times per week: _____
Sedentary _____ Low_____ Moderate _____ Intense _____
Sleep: Sleep all night? _____**Insomnia?** _____
Typical Diet: Breakfast: _____
Lunch:_____
Dinner: _____
Snacks: _____
Caffeine: Coffee _____ Tea _____ Sodas _____Chocolate___

Syosset Endocrinology

Patient's Name: _____

Family History (Please state disease and if deceased, at what age)

Father:_____
_____

Mother:_____
_____

Brother:_____
_____

Sister:_____
_____

Other family: _____
_____