SAN DIEGO COASTAL ENDOCRINOLOGY GROUP, a Medical Corporation

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Date: _____

Name: _____ Age: _____ Height: _____ Marital Status:_____

Do you have any allergies to medications? _____ YES _____ NO

Habits:

How much alcohol do you drink on a daily basis? _____

How much do you smoke and for how many years? _____

Do you use recreational drugs? _____ YES _____ NO

Medical History:

Do you have a thyroid problem? _____ YES _____ NO

If YES, Please give details: _____

_____

Have you ever been treated with radiation? _____ YES _____ NO

Do you have any of the following? (***please check***)

_____ Weight Change
_____ High Blood Pressure
_____ Heart Attack
_____ Palpitations / Irregular heart beat
_____ Loss of Consciousness
_____ Stroke
_____ High Cholesterol
_____ Chest Pain
_____ Heart Failure
_____ Shortness of Breath
_____ Numbness or Burning
_____ Infections

Date of last eye exam by an ophthalmologist: _____/_____/_____

What other symptoms do you have?: _____

_____

If you have diabetes, please answer the following:

When were you first diagnosed with diabetes? _____

Have you ever been hospitalized because of diabetes, Please give details: _____

_____

If you are on insulin, when was the insulin first started? _____

What are the results of recent finger-stick glucose tests done at home? _____

_____

Hospitalizations: Date and reasons for hospitalizations/surgeries you have had:_____

_____

Who in your family has:

_____ Thyroid disease _____ Heart Disease _____ Diabetes _____ Cancer

Medications: List your medications (including over the counter meds) and the doses taken: _____

_____

_____

Females: Do you have any of the following? (*please check*)

Are you having periods? ___ YES ___ NO Do you have breast milk leakage? ___YES ___NO

Are your periods regular? ___ YES ___ NO Do you have Excessive body hair ___YES ___NO