North Atlanta
NAE&D
Endocrinology
& Diabetes, P.C.

Date: _____

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history.
Information contained here will be released only if you have authorized us to do so.

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth: ____ /____ /____ Sex: ❑ Female ❑ Male Marital Status: ____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Pharmacy Address: _____

PCP: _____ **Referring Doctor:** _____

Past Medical History:
Check any conditions you have had:

- ❑ Abnormal EKG
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Asthma
- ❑ Bone Disease
- ❑ Breast Lump
- ❑ Cancer
  Type: _____
- ❑ Coronary Artery Disease (Heart Disease)
- ❑ Decreased Libido
- ❑ Depression
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Dyslipidemia (High Cholesterol)
- ❑ Emphysema
- ❑ Endocrine Disorder
- ❑ Gallbladder Disease
- ❑ Heart Attack
- ❑ Hepatitis
- ❑ Hypertension (High Blood Pressure)
- ❑ Hyperthyroidism (Overactive Thyroid)
- ❑ Hypothyroidism (Underactive Thyroid)
- ❑ Impotence/ED
- ❑ Infertility
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Meningitis
- ❑ Mental Illness
- ❑ Migraines
- ❑ Nipple Discharge
- ❑ Osteoporosis
- ❑ Phlebitis
- ❑ Postmenopausal Bleeding
- ❑ Seizures
- ❑ Serious Injury
- ❑ Stomach Ulcer
- ❑ Stroke
- ❑ Thyroid Cancer
- ❑ Thyroid Nodule
- ❑ Tuberculosis

Have you ever had External Beam Neck Radiation?
❑ No ❑ Yes Date: _____
Other major diseases: _____
_____

Health Maintenance: Fill in all that apply
Date of last eye exam: _____
Date of last prostate exam: _____
Date of last PAP test: _____
Previous mammogram: _____
Glasses or contacts? ❑ No ❑ Yes ❑ Both

Past Surgical History:
Have you ever had surgery? ❑ Yes ❑ No
If yes, please list:
Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____
Recent Hospitalizations: _____
_____

Medications:
List all medicines and supplements you take:

Medicine or Supplement	How much?	How often?

Allergies:
Are you allergic to any medications? ❑ Yes ❑ No
Please list: _____
Are you allergic to latex? ❑ Yes ❑ No
Are you allergic to any foods? ❑ Yes ❑ No
Please list: _____
_____

Family History: Parents, Grandparents, Brothers, Sisters, Children, Aunts and Uncles

Yes	No	Disease:	Relative(s):
❑	❑	Asthma	_____
❑	❑	Cancer	_____
❑	❑	Diabetes	_____
❑	❑	Heart Disease	_____
❑	❑	High Blood Pressure	_____
❑	❑	Kidney Disease	_____
❑	❑	Mental Illness	_____
❑	❑	Other Glandular Disease	_____
❑	❑	Stomach Ulcers	_____
❑	❑	Stroke	_____
❑	❑	Thyroid Disease/ Goiter	_____
❑	❑	Tuberculosis	_____

Social History:

Do you use alcohol?

❑ Never ❑ Former ❑ Some Days ❑ Everyday

Do you drink caffeinated beverages?

❑ Yes ❑ No

Have you ever smoked?

❑ Never ❑ Former ❑ Some Days ❑ Everyday

If yes, how many years have you smoked? _____

Packs per day? _____

How often do you exercise?

❑ Never ❑ 1x per wk ❑ 2-3x per wk ❑ 4+x per wk

Are your parents living? ❑ Mom ❑ Dad

How many siblings do you have? _____

How many children do you have? _____

Highest level of education? _____

Occupation: _____

Symptoms: Please check the appropriate boxes indicating the symptoms you have had within the last year.

CONSTITUTIONAL
- ❑ Change in weight of more than 10 lbs.
- ❑ Night Sweats
- ❑ Fatigue

EYES
- ❑ Trouble with Vision
- ❑ Changes in Vision
- ❑ Double Vision
- ❑ Blurred Vision

HEAD ENT
- ❑ Changes in Hearing
- ❑ Hoarseness
- ❑ Headaches

BREASTS
- ❑ Changes in Skin
- ❑ Masses
- ❑ Nipple Discharge

PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression
- ❑ Difficulty Breathing

CARDIOVASCULAR
- ❑ Palpitations
- ❑ Chest Pain
- ❑ Difficulty Breathing on Exertion
- ❑ Lower Extremity Swelling
- ❑ Loss of Consciousness

RESPIRATORY
- ❑ Chronic Cough
- ❑ Coughing Blood
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Difficulty Breathing

GASTROINTESTINAL
- ❑ Difficulty Swallowing
- ❑ Reflux
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in Stools
- ❑ Changes in Bowel Habits

GENITOURINARY
- ❑ Painful or Difficult Urination
- ❑ Frequency
- ❑ Excessive Urination at Night
- ❑ Post Void Dribbling
- ❑ Blood in Urine
- ❑ Urgency

INTEGUMENT/SKIN
- ❑ Pigmentation Changes
- ❑ Skin Dryness
- ❑ Rash
- ❑ New Skin Lesions
- ❑ Changes to Existing Skin Lesions/Moles
- ❑ Hair Growth Change

NEUROLOGIC
- ❑ Tremors
- ❑ Speech Difficulties
- ❑ Paralysis
- ❑ Tingling or Numbness
- ❑ Seizures
- ❑ Muscular Weakness

MUSCULOSKELETAL
- ❑ Muscle Cramps
- ❑ Nocturnal Leg Cramps
- ❑ Joint Pain
- ❑ Joint Swelling

ENDOCRINE
- ❑ Cold Intolerance
- ❑ Heat Intolerance
- ❑ Drinking More Fluids
- ❑ Excessive Urination
- ❑ Excessive or Abnormal Thirst
- ❑ Excessive Hair Growth
- ❑ Hot Flashes

HEMA-LYMPH
- ❑ Lymph Node Enlargement
- ❑ Easy Bleeding
- ❑ Easy Bruising

ALLERGIC-IMMUNO
- ❑ Sinus Allergy
- ❑ Hay Fever
- ❑ Allergic Dermatitis

I certify these two pages to be accurate and current to the best of my knowledge (Please sign and date below)

Patient Signature: _____ **Date:** _____