Selkirk Endocrinology

NEW PATIENT
MEDICAL HISTORY FORM

NAME: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

MEDICAL CONDITIONS
(Please circle or fill in)

Hypertension
Atrial fibrillation
Congestive heart failure
Valvular heart disease
Myocardial infarction
Coronary artery disease
Peripheral vascular disease

Asthma
Chronic obstructive pulmonary disease

Diabetes
Diabetic foot ulcer
Diabetic neuropathy
Diabetic eye disease (retinopathy)
Hypothyroid
Hyperthyroid
Thyroid nodule
Graves disease
Graves eye disease

Acid reflux disease
Crohn's disease
Ulcerative colitis
Hepatitis A B C
Primary biliary cirrhosis
Pancreatitis

Menopause
Irregular menstrual cycles
Polycystic ovarian syndrome
Hypogonadism
Gynecomastia
Prolactinoma
Pituitary adenoma

Osteoporosis
Vertebral fracture
Hip fracture
Chronic kidney disease

Cancer: _____
Anemia
Deep vein thrombosis (blood clots)

High cholesterol
Obesity

Osteoarthritis
Rheumatoid Arthritis
Lupus
Ankylosis spondylitis
Fibromyalgia
Chronic pain syndrome

Seizures
Migraines
Peripheral neuropathy
Sleep apnea

Anorexia
Schizophrenia
Post traumatic stress disorder
Depression
Anxiety

Other:_____

PREVIOUS SURGERIES

Gall bladder surgery
Appendectomy
Total hysterectomy
Ovary removal
Transsphenoidal pituitary surgery
Tonsilectomy
Coronary artery bypass graft (CABG)
Thyroidectomy
Parathyroidectomy
Coronary artery stenting
Hip replacement
Knee replacement
C-section
Toe/foot amputation
Gastric bypass surgery. Type: _____
Other: _____

FAMILY MEDICAL HISTORY

Father: _____
Mother: _____
Siblings: _____

SOCIAL HISTORY

Tobacco use?	Yes	No	Quit
Alcohol use?	Yes	No	Quit
Marijuana use?	Yes	No	Quit
Recreational drug use?	Yes	No	Quit

Single Married Divorced
Widowed Signifiant other

Occupation: _____/Retired

Date: _____

Signature: _____

Selkirk Endocrinology

NEW PATIENT
MEDICAL HISTORY FORM

REVIEW OF SYSTEMS

GENERAL
Fatigue/low energy
Weight loss
Weight gain
Fever
Chills
Excessive sweating
Hot flushes
Night sweats
Insomnia
Weakness

EYES
Decreased vision
Double vision
Eye pain
Blurry vision
Flashing lights
Red eyes

EAR, NOSE, AND THROAT
Decreased hearing
Ear pain
Sinus congestion
Hoarseness
Sore throat
Tooth ache
Jaw pain
Vertigo (room spinning sensation)
Difficulty swallowing

CARDIOVASCULAR
Chest pain/pressure with exertion or at rest
Heart palpitations
Lightheaded
Swelling of hands or feet
Shortness of breath while lying down
Fainting

RESPIRATORY
Cough
Excess phlegm
Shortness of breath
Wheezing
Sleep apnea

GASTROINTESTINAL
Heartburn
Loss of appetite
Nausea
Vomiting
Abdominal pain
Diarrhea
Blood in the stool
Tar like stool
Rectal bleeding

GENITOURINARY
Pain with urination
Blood in the urine
Frequent night time urination
Abnormal discharge
Incontinence
Low sex drive
Erectile dysfunction
Vaginal dryness
Irregular/lack of periods
Testicular pain or mass

MUSCULOSKELETAL
Joint pain
Muscle cramps
Joint swelling
Joint redness
Back pain
Joint stiffness
Muscle aches/pain
Loss of height

SKIN
Rash
Itching
Dryness
Coarse chin hair
Acne
Scalp hair loss
Skin tags

NEUROLOGY
Weakness
Numbness
Headaches
Seizures
Neuropathy
Tremors
Memory loss
Excessive sleepiness
Difficulty concentrating

MENTAL
Anxiety
Depression
Thoughts of suicide
Auditory hallucinations
Visual hallucinations

ENDOCRINE
Heat intolerance
Cold intolerance
Excessive urination
Excessive thirst
Hot flushes
Milky nipple discharge
Excess hunger

BLOOD
Enlarged lymph glands
Easy bruising/bleeding
Night sweats

ALLERGIES
Seasonal allergies
Hives

Medications
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medication Allergies
_____
_____
_____
_____

Date: _____

Signature: _____