Endocrinology Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name____ Date of birth___________________________

Address____

Local phone number________________________ Alternative phone number________________

Referring Provider: ______________________ Primary Care Provider: _________________________________

Special Communication Needs:		
Language preference:		
If 'yes' to any of the questions below, how can we assist?		
Visual impairment	☐ Yes ☐ No	
Hearing impairment	☐ Yes ☐ No	
Speech impairment	☐ Yes ☐ No	
Cognitive impairment	☐ Yes ☐ No	
Sensory impairment	☐ Yes ☐ No	

Personal Health History	
Please check past(P) or current(C) problems or conditions	
P☐ C☐ Hypertension	P☐ C☐ Bowel/digestive problem
P☐ C☐ High cholesterol	P☐ C☐ Atrial Fibrillation
P☐ C☐ Diabetes	P☐ C☐ Seizures
P☐ C☐ Heart attack or angina	P☐ C☐ Headaches
P☐ C☐ Irregular heart rhythm	P☐ C☐ Stroke
P☐ C☐ Congestive heart failure	P☐ C☐ Prostate problem
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Breast problem
	P☐ C☐ Urinary tract infections
P☐ C☐ Pneumonia	P☐ C☐ Arthritis
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem
	P☐ C☐ Bleeding disorder
P☐ C☐ Asthma	P☐ C☐ Addiction Issues
P☐ C☐ Osteoporosis/Osteopenia	P☐ C☐ Depression
P☐ C☐ Cancer, Type:	P☐ C☐ Anxiety
P☐ C☐ Stomach ulcer	P☐ C☐ Mental Illness
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Other:
P☐ C☐ Liver Disease, Type:	

Previous Surgical Procedures	
Please check if you have had any of the following	
Procedure	Year
☐ Heart surgery	
☐ Carotid artery surgery	
☐ Vascular surgery / stent	
☐ Abdominal aneurysm repair	
☐ Hysterectomy	
☐ Gallbladder removed	
☐ Appendix removed	
☐ Tonsillectomy	
☐ Joint replacement ☐ Hip ☐ Right ☐ Left ☐ Knee ☐ Right ☐ Left	
☐ Spine Surgery ☐ Neck ☐ Back	
☐ Breast cancer surgery	
☐ Prostate cancer surgery	
☐ Hernia	
☐ Other: ____________________	

Social History:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Live here year round? ☐ Yes ☐ No If no, Part time location: ______________________________
Occupation: **Concerns**: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting
Tobacco use: ☐ Never ☐ Quit (when)___________ ☐ Current smoker: Packs/day, how many years____________________
Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often______________
Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often______________
Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current Describe:____

Current Health Concerns			
Please check problems or conditions that you are CURRENTLY experiencing			
☐ Chest pain	☐ Rectal bleeding	☐ Eye pain	☐ Nervousness
☐ Shortness of breath	☐ Black/tarry stools	☐ Loss of vision	☐ Pain in testicles
☐ Wheezing	☐ Weight loss	☐ Double vision	☐ Loss of libido
☐ Cough	☐ Weight gain	☐ Memory loss	☐ Impotence
☐ Coughing up blood	☐ Loss of appetite	☐ Ringing in ears	☐ Breast pain
☐ Sore throat	☐ Difficulty swallowing	☐ Pain in ears	☐ Breast discharge
☐ Nasal congestion	☐ Diarrhea	☐ Nose bleeds	☐ Other (please describe below)
☐ Irregular heartbeat	☐ Constipation	☐ Hoarseness	
☐ Fast heartbeat	☐ Painful urination	☐ Easy bleeding	
☐ High blood pressure	☐ Blood in urine	☐ Easy bruising	
☐ Low blood pressure	☐ Urine frequency	☐ Rash	
☐ Lightheadedness	☐ Decrease in urine flow	☐ Changes in mole	**Females - Please complete**
☐ Dizziness/fainting	☐ Urine leakage	☐ Sore that won't heal	Menstrual flow:
☐ Abdominal pain	☐ Headaches, frequent	☐ Fatigue/lethargy	☐ Reg. ☐ Irreg. ☐ Pain/cramps
☐ Heartburn	☐ Hemorrhoids	☐ Insomnia	Days of flow __ Length of cycle__
☐ Indigestion	☐ Loss of strength	☐ Forgetfulness	1st day of last period____________
☐ Ankle swelling	☐ Balance problems	☐ Depression	☐ Pain or bleeding after sex
☐ Nausea	Pain, weakness, or numbness in		Number of pregnancies _________
☐ Vomiting	☐ Arms ☐ Hips	☐ Back	Miscarriages__________________
☐ Vomiting blood	☐ Legs ☐ Neck	☐ Shoulders	Birth control method ___________
☐ Change in bowel habits	☐ Hands ☐ Feet	☐ Abdomen	Menopause ☐ Y ☐ N Age: _______

Family History			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:			
Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: ___________________		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Health Maintenance:

Please check whether you have had the following preventive services and enter the year of the service

Immunizations			Last Occurrence	Tests			Last Occurrence
Tetanus vaccine / Tdap	☐ Yes	☐ No		Pap smear/pelvic	☐ Yes	☐ No	
Pneumonia vaccine	☐ Yes	☐ No		Mammogram	☐ Yes	☐ No	
Influenza vaccine	☐ Yes	☐ No		Bone Density	☐ Yes	☐ No	
Shingles vaccine	☐ Yes	☐ No		Colonoscopy	☐ Yes	☐ No	
Hepatitis ☐ A ☐ B	☐ Yes	☐ No		Prostate test	☐ Yes	☐ No	
Guardasil (HPV)	☐ Yes	☐ No		Chest X-Ray	☐ Yes	☐ No	

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: ____________________________________ **Phone**: _____________________ **Store #**: ______________________

Location Description: ____

<table>
<tr><th colspan="2">Medical Providers:</th></tr>
<tr><th colspan="2">In order that we can best coordinate your care, please list any medical providers you see outside of this practice</th></tr>
<tr><td>Primary Care Provider
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Nephrologist
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
<tr><td>Cardiologist
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Psychiatrist/Psychologist
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
<tr><td>Oncologist
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Allergist
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
<tr><td>Urologist
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Gynecologist
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
<tr><td>Gastroenterologist
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Pulmonologist
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
<tr><td>Ophthalmologist
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Podiatrist: ______________________
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
<tr><td>Other: ______________________
Name: ____
Phone: __________________________ Last Seen:___________</td><td>Other: ______________________
Name: ____
Phone: _______________________ Last Seen: ___________</td></tr>
</table>

Patient/Guardian Signature:____ Date:_________________________