



Initial Assessment

To help us meet your needs, please fill out this entire form to the best of your ability, and be sure we receive it **at least 3 business days** before your consult appointment so we can prepare for your visit.

Please print legibly. Completed by Patient Other _____

General Information

Name: _____ Today's date: _____

Male Female Birthdate: _____ Age: _____ Appointment date: _____

Who referred you to our practice? _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Marital Status: Single Married Widowed Separated Divorced

Spouse or Parent Name: _____ With whom do you live? _____

Your employer: _____ Occupation: _____

What hours do you work? _____ Highest education level achieved: _____

Have you ever seen an endocrinologist? No Yes If yes, who and when? _____

Possible barriers to learning: Vision Hearing Literacy Memory None

Does anyone help you with your health care? No Yes. If yes, who? _____

Please list and explain the problem(s) for which you were referred to us:

Current Medications

Please bring all medicine bottles with you

Please list ALL medications (prescription & non-prescription) that you currently take:

	Drug Name	Dose (mg)	When taken (times of day)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____

Please list any medications (prescription and non-prescription) that you are **allergic** to, or have had **side effects** from: None

Drug Name	Describe allergy or side effect
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy:

Mail order: _____ Preferred
Local: _____ Preferred

Other Health History

Do you smoke? Never did Quit (when? _____) Yes

At what age did you start smoking? _____ Now smoke _____ packs per day.

Do you drink alcohol? No Yes. If so, what do you drink? How much? How often?

Do you use recreational drugs? No Yes. If so, what do you use? How much? How often?

Please list any other past or current medical problems: None

1.

9.

2.

10.

3.

11.

4.

12.

5.

13.

6.

14.

7.

15.

8.

16.

Please list any surgeries (and estimated dates): None

1.

4.

2.

5.

3.

6.

Primary care provider: _____

Please list any other doctors you see: None

1.

4.

2.

5.

3.

6.

Symptom Checklist

I am pregnant or may be pregnant

Please check and explain any symptoms you have had recently:

<p>General</p> <ul style="list-style-type: none"><input type="checkbox"/> Appetite increase<input type="checkbox"/> Appetite decrease<input type="checkbox"/> Weight loss<input type="checkbox"/> Weight gain<input type="checkbox"/> Excessive thirst<input type="checkbox"/> Fatigue (tired)<input type="checkbox"/> Unexplained fevers<input type="checkbox"/> Heat intolerance<input type="checkbox"/> Cold intolerance<input type="checkbox"/> Excessive sweating<input type="checkbox"/> Trouble sleeping<input type="checkbox"/> Trouble concentrating <p>Skin</p> <ul style="list-style-type: none"><input type="checkbox"/> Rashes<input type="checkbox"/> Sores<input type="checkbox"/> Easy bruising<input type="checkbox"/> Itching<input type="checkbox"/> Dryness<input type="checkbox"/> Color changes<input type="checkbox"/> Hair changes<input type="checkbox"/> Nail changes<input type="checkbox"/> Yellow skin or eyes <p>Eyes</p> <ul style="list-style-type: none"><input type="checkbox"/> Glasses or contacts<input type="checkbox"/> Vision loss<input type="checkbox"/> Eye pain<input type="checkbox"/> Eye redness<input type="checkbox"/> Blurred vision<input type="checkbox"/> Double vision<input type="checkbox"/> Flashing lights<input type="checkbox"/> Glaucoma<input type="checkbox"/> Cataracts <p>Ears</p> <ul style="list-style-type: none"><input type="checkbox"/> Decreased hearing<input type="checkbox"/> Ringing in ears<input type="checkbox"/> Earache<input type="checkbox"/> Ear drainage <p>Nose</p> <ul style="list-style-type: none"><input type="checkbox"/> Stuffiness<input type="checkbox"/> Discharge<input type="checkbox"/> Hay fever<input type="checkbox"/> Sinus pain	<p>Mouth and Throat</p> <ul style="list-style-type: none"><input type="checkbox"/> Full dentures<input type="checkbox"/> Partial dentures<input type="checkbox"/> Bleeding gums<input type="checkbox"/> Sore tongue<input type="checkbox"/> Dry mouth<input type="checkbox"/> Sore throat<input type="checkbox"/> Hoarseness<input type="checkbox"/> Thrush<input type="checkbox"/> Non-healing sores<input type="checkbox"/> Last dental visit date: <p>Neck</p> <ul style="list-style-type: none"><input type="checkbox"/> Enlarged thyroid (goiter)<input type="checkbox"/> Lumps<input type="checkbox"/> Swollen lymph nodes <p>Breasts</p> <ul style="list-style-type: none"><input type="checkbox"/> Lumps<input type="checkbox"/> Pain<input type="checkbox"/> Discharge<input type="checkbox"/> Breastfeeding currently<input type="checkbox"/> Last mammogram date: <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Cough<input type="checkbox"/> Sputum<input type="checkbox"/> Coughing up blood<input type="checkbox"/> Shortness of breath<input type="checkbox"/> Wheezing<input type="checkbox"/> Painful breathing <p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> High blood pressure<input type="checkbox"/> Chest pain, discomfort or tightness<input type="checkbox"/> Palpitations (heart racing or skipping)<input type="checkbox"/> Shortness of breath with activity<input type="checkbox"/> Difficulty breathing lying down<input type="checkbox"/> Sudden awakening from sleep short of breath<input type="checkbox"/> Swelling in legs or feet<input type="checkbox"/> Calf pain with walking	<p>Gastrointestinal</p> <ul style="list-style-type: none"><input type="checkbox"/> Swallowing trouble<input type="checkbox"/> Heartburn<input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting<input type="checkbox"/> Abdominal pain<input type="checkbox"/> Change in bowel habits<input type="checkbox"/> Constipation<input type="checkbox"/> Diarrhea<input type="checkbox"/> Rectal bleeding<input type="checkbox"/> Black stools<input type="checkbox"/> Last colonoscopy date: <p>Urinary</p> <ul style="list-style-type: none"><input type="checkbox"/> Frequent urination<input type="checkbox"/> Urgency<input type="checkbox"/> Burning or pain<input type="checkbox"/> Blood in urine<input type="checkbox"/> Decreased urine flow<input type="checkbox"/> Incontinence (leaking)<input type="checkbox"/> Kidney stones (ever) <p>Reproductive Health</p> <ul style="list-style-type: none"><input type="checkbox"/> Menstrual irregularities<input type="checkbox"/> Menopause symptoms<input type="checkbox"/> Sexual problems <p>Musculoskeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Muscle pain<input type="checkbox"/> Muscle cramps<input type="checkbox"/> Joint pain<input type="checkbox"/> Joint swelling<input type="checkbox"/> Neck pain<input type="checkbox"/> Back pain <p>Neurologic</p> <ul style="list-style-type: none"><input type="checkbox"/> Headaches<input type="checkbox"/> Dizziness<input type="checkbox"/> Muscle weakness<input type="checkbox"/> Numbness<input type="checkbox"/> Tingling<input type="checkbox"/> Tremor <p>Mental Health</p> <ul style="list-style-type: none"><input type="checkbox"/> Nervousness or anxiety<input type="checkbox"/> Stress<input type="checkbox"/> Depression
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Family History

Please list health problems in your family, such as:

- ✓ Diabetes (include “type 1” or “type 2” and age of diagnosis if known)
- ✓ High cholesterol
- ✓ High blood pressure
- ✓ Heart disease
- ✓ Stroke
- ✓ Thyroid problems
- ✓ Cancer (include type if known)
- ✓ Depression

Include cause of (and age at) death if known.

	Year of Birth	Healthy	Died	Health problems:
Father		<input type="checkbox"/>	<input type="checkbox"/>	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 1		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 2		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 3		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 4		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 1		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 2		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 3		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 4		<input type="checkbox"/>	<input type="checkbox"/>	
Son 1		<input type="checkbox"/>	<input type="checkbox"/>	
Son 2		<input type="checkbox"/>	<input type="checkbox"/>	
Son 3		<input type="checkbox"/>	<input type="checkbox"/>	
Son 4		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 1		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 2		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 3		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 4		<input type="checkbox"/>	<input type="checkbox"/>	

Thank you. Please be sure to return completed form promptly.

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