UB|MD
INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

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ENDOCRINOLOGY

INITIAL HISTORY AND PHYSICAL INFORMATION

REFERRING MD: _____ DATE: _____

PATIENT NAME: _____ DOB: _____

REASON FOR VISIT

	PHYSICIANS COMMENTS

ALLERGIES (MEDICATIONS AND FOOD) ☐ **NONE**

NAME	REACTION

CURRENT MEDICATION **Pharmacy**: _____ **Phone**: _____

NAME	DOSE	FREQUENCY

PAST MEDICAL HISTORY

CONDITION	CHECK ONE	HOW LONG?	PHYSICIANS COMMENTS
Hypertension	☐ YES ☐ NO		
Heart Disease	☐ YES ☐ NO		
Stroke	☐ YES ☐ NO		
Diabetes	☐ YES ☐ NO		
Thyroid Disease	☐ YES ☐ NO		
Kidney Disease	☐ YES ☐ NO		
Liver Disease	☐ YES ☐ NO		
OTHER:			

PATIENT NAME: _____ DOB: _____

SURGICAL HISTORY ☐ **NONE**

YEAR	TYPE OF SURGERY	PHYSICIAN AND HOSPITAL

FAMILY HISTORY

FAMILY MEMBER	AGE	MEDICAL CONDITIONS	IF DECEASED, CAUSE OF DEATH
Mother			
Father			
Brother(s)			
Sister(s)			
Grandfather			
Grandmother			
Other			
Are you adopted?	☐ YES ☐ NO		

EMERGENCY ROOM OR HOSPITAL VISITS

In the past five (5) years, have you been to the Emergency Room or Hospitalized?

DATE	REASON	TREATMENT

IMMUNIZATIONS

Please verify the immunizations you have had and write the last year of injection:

	IMMUNIZATION	YEAR
☐	Tetanus/diphtheria	
☐	Pneumonia vaccine	
☐	Influenza vaccine	
☐	Measles, mumps, rubella (MMR)	
☐	Hepatitis B vaccine	

DO YOU HAVE A HEALTH CARE PROXY? ☐ YES ☐ NO

DO YOU HAVE ADVANCED DIRECTIVES? ☐ YES ☐ NO

If no, would you like information about it? ☐ YES ☐ NO

PATIENT NAME: _____ DOB: _____

SOCIAL HISTORY

DO YOU SMOKE?	☐ YES ☐ NO
If yes, how much?	
When did you quit?	
DO YOU CONSUME ALCOHOL?	☐ YES ☐ NO
If yes, how much?	
When did you quit?	
DO YOU USE RECREATIONAL DRUGS?	☐ YES ☐ NO
If yes, what kind?	
If yes, how much/often?	
DO YOU EXERCISE REGULARLY?	☐ YES ☐ NO
If yes, what kind and how often?	
MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOW	
DO YOU WEAR A HELMET WHILE RIDING A BIKE OR MOTORCYCLE?	☐ YES ☐ NO
DO YOU WEAR A SEAT BELT?	☐ YES ☐ NO
ANY ENVIRONMENTAL EXPOSURES?	☐ YES ☐ NO
If yes, what kind?	
DO YOU HAVE SMOKE DETECTORS IN YOUR HOME?	☐ YES ☐ NO
DO YOU LIVE ALONE?	☐ YES ☐ NO
HAVE YOU SEEN A DENTIST IN THE LAST SIX MONTHS?	☐ YES ☐ NO
HAVE YOU SEEN AN EYE DOCTOR IN THE LAST TWO YEARS?	☐ YES ☐ NO

SEXUAL HISTORY

Have you had more than one sexual partner in the last five years?	☐ YES ☐ NO
Sexual Activity ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Celibate ☐ Other	
Have you been tested for HIV/AIDS?	☐ YES ☐ NO
If not, do you want to be tested?	☐ YES ☐ NO
FOR WOMEN:	
Do you examine your breasts at least once per month?	☐ YES ☐ NO
Do you get the minimum daily requirements of calcium?	☐ YES ☐ NO
Have you ever used oral contraceptives / birth control pills?	☐ YES ☐ NO
Are you currently taking birth control?	☐ YES ☐ NO
If yes, what type?	
Have you experienced menopause (change of life)?	☐ YES ☐ NO
Last mammogram Date:	☐ NORMAL ☐ ABNORMAL
Where?	
Last Pap Smear Date:	☐ NORMAL ☐ ABNORMAL
Where?	
Last menstrual cycle Date:	
FOR MEN:	
Do you examine your testicles each month?	☐ YES ☐ NO
Do you use protection for STD's?	☐ YES ☐ NO

PATIENT'S NAME: _____ DOB: _____

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING, WHICH IS OF CONCERN?

GENERAL HEALTH AND WELL-BEING

Recent weight change	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Headaches	☐ YES	☐ NO

EYES

Eye disease or injury	☐ YES	☐ NO
Wear glasses/contact lens	☐ YES	☐ NO
Blurred or double vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO

EARS, NOSE, THROAT

Hearing loss	☐ YES	☐ NO
Ringing in the ears	☐ YES	☐ NO
Perforated (hole in) eardrums	☐ YES	☐ NO
Earaches or drainage	☐ YES	☐ NO
Sinus problem	☐ YES	☐ NO
Seasonal nasal discharge (allergies)	☐ YES	☐ NO
Loss of smell	☐ YES	☐ NO
Nose bleeds	☐ YES	☐ NO
Mouth sores	☐ YES	☐ NO
Bleeding gums	☐ YES	☐ NO
Bad breath or bad taste	☐ YES	☐ NO
Sore throat or voice change	☐ YES	☐ NO
Swollen glands in neck	☐ YES	☐ NO
Problems with swallowing	☐ YES	☐ NO

HEART AND CIRCULATORY SYSTEM

Heart trouble	☐ YES	☐ NO
Chest pains	☐ YES	☐ NO
Palpitations or flutter of heart	☐ YES	☐ NO
Swelling of feet, ankles or hands	☐ YES	☐ NO
Shortness of breath that awakens you at night	☐ YES	☐ NO
Cramping in legs	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO

LUNGS

Frequent coughing	☐ YES	☐ NO
Spitting up blood	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO
Asthma or wheezing	☐ YES	☐ NO
Do you snore?	☐ YES	☐ NO
Are you tired during the daytime?	☐ YES	☐ NO
Have you been told that you stop breathing or gasp for air while asleep?	☐ YES	☐ NO

GENITOURINARY

Frequent urination (voiding)	☐ YES	☐ NO
Burning or painful urination	☐ YES	☐ NO
Blood in urine or discoloration	☐ YES	☐ NO
Change of force or strain when urination	☐ YES	☐ NO
Inability to control bladder or dribbling	☐ YES	☐ NO
Getting up at night to pass urine	☐ YES	☐ NO
Kidney stones	☐ YES	☐ NO
Male – testicle pain	☐ YES	☐ NO
Female – pain with periods	☐ YES	☐ NO
Female – irregular periods	☐ YES	☐ NO
Female – vaginal discharge	☐ YES	☐ NO

Female - # pregnancies _____

miscarriages _____

GASTROINTESTINAL

Loss of appetite	☐ YES	☐ NO
Change in bowel movements	☐ YES	☐ NO
Nausea or vomiting	☐ YES	☐ NO
Heartburn or chronic indigestion	☐ YES	☐ NO
Frequent diarrhea	☐ YES	☐ NO
Painful bowel movements or constipation	☐ YES	☐ NO
Red blood in stool or tarry black stools	☐ YES	☐ NO
Stomach pains	☐ YES	☐ NO
Hemorrhoids or rectal bleeding	☐ YES	☐ NO

BONES, JOINTS, MUSCLES

Joint pain, stiffness, or swelling	☐ YES	☐ NO
Weakness of muscles or joints	☐ YES	☐ NO
Muscle pain or cramps	☐ YES	☐ NO
Back pain	☐ YES	☐ NO
Cold extremities (legs)	☐ YES	☐ NO
Difficulty in walking	☐ YES	☐ NO
Frequent falls	☐ YES	☐ NO

SKIN

Rash or itching	☐ YES	☐ NO
Change in skin color	☐ YES	☐ NO
Change in hair or nails	☐ YES	☐ NO
Varicose veins	☐ YES	☐ NO
Breast pain	☐ YES	☐ NO
Breast lump/s	☐ YES	☐ NO
Breast discharge	☐ YES	☐ NO

BRAIN AND NERVOUS SYSTEM

Frequent or recurring headaches	☐ YES	☐ NO
Lightheaded or dizzy	☐ YES	☐ NO
Convulsions or seizures	☐ YES	☐ NO
Numbness or tingling sensations	☐ YES	☐ NO
Tremors	☐ YES	☐ NO
Paralysis	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Temporary blindness	☐ YES	☐ NO
Loss of consciousness	☐ YES	☐ NO
Weakness of any extremity (arm or leg)	☐ YES	☐ NO

MENTAL HEALTH

Memory loss or confusion	☐ YES	☐ NO
Nervousness	☐ YES	☐ NO
Depression	☐ YES	☐ NO
Sleep problems	☐ YES	☐ NO
Are you seeing or have you seen a Psychologist or a counselor in the past	☐ YES	☐ NO

ENDOCRINE

Glandular or hormone problems	☐ YES	☐ NO
Thyroid disease	☐ YES	☐ NO
Excessive thirst or urination	☐ YES	☐ NO
Heat or cold intolerance	☐ YES	☐ NO
Dry skin	☐ YES	☐ NO
Chang in hat or glove size	☐ YES	☐ NO

BLOOD AND LYMPH

Slow to heal after cuts	☐ YES	☐ NO
Easily bruise or bleed	☐ YES	☐ NO
Anemia	☐ YES	☐ NO
Phlebitis	☐ YES	☐ NO