J. Dustin Bernard D.O. Endocrinologist

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The Endocrinology Clinic Health Questionnaire and Medical History

NAME ______________________________________ **NICK NAME**______________ **DOB**________

Why are you seeing Dr. Bernard Today?____

Referring Doctor?____

CURRENT MEDICAL PROBLEMS

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ALLERGIES to FOODS or DRUGS (reaction that occurs) ___________________________

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MEDICAL HISTORY

List any **significant medical illness** (HIGH BLOOD PRESSURE, DIABETES, THYROID PROBLEMS, CANCER, HEART PROBLEMS, etc.) or injuries (fractures, etc.)

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CURRENT MEDICATIONS

(Please include hormones, birth control pills, herbal, vitamins, diet supplements, or over-the-counter medicines that you take on a regular basis. Attach a separate sheet of paper if needed.)

MEDICATION	**DOSE**	**FREQUENCY**

SURGICAL HISTORY

OPERATION	REASON	DATE

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FAMILY HISTORY

Indicate any major health problems of relatives.

RELATIVE	D.O.B.*	HEALTH PROBLEM/ CAUSE of DEATH	AGE AT DEATH
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
FATHER'S FATHER			
FATHER'S MOTHER			
MOTHER'S FATHER			
MOTHER'S MOTHER			
CHILDREN			

*D.O.B. : Date of Birth

Review of Your Past Medical History

Are you **CURRENTLY** having any of the following symptoms? Please circle or check **ONLY** any symptoms that you have **RIGHT NOW**.

CONSTITUTIONAL- ☐Fever, ☐Chills, ☐Weight gain/ loss, ☐↓Sense of Wellbeing, ☐↓ or ↑ appetite, ☐Energy loss, ☐Sweats, ☐Frequently ill.

SKIN- ☐ Rashes, ☐ Itchy skin, ☐ Color change, ☐ New or changing moles, ☐ Lumps, ☐ Nail Changes, ☐ Hair Changes, ☐ Skin cancer

HEAD- ☐Headaches, ☐ Eye pain, ☐Double vision, ☐Blurry vision, ☐Blind spots, ☐Glaucoma, ☐Cataracts, ☐Laser surgery, ☐Loss of hearing, ☐Ringing in the ears, ☐Bloody noses

Last yearly eye exam____________________ Eyes Dilated? ○Yes ○No

NOSE and THROAT- ☐Sinus trouble, ☐Hay fever/Seasonal allergies, ☐Hoarseness, ☐Change in voice, ☐Nose bleeds, ☐Change in taste or smell, ☐Nasal polyps, ☐History of radiation treatment to face or neck, ☐History of thyroid disease , ☐Difficulty swallowing liquids or solids

NECK-☐Swollen glands,☐Difficulty swallowing,☐Lumps,☐Pain in the neck region,☐Nodules

BREAST- ☐Pain, ☐History of lumps, ☐Nipple discharge

CARDIAC- ☐Heart palpitations, ☐Fast heart beat, ☐Chest pain, ☐History of heart murmurs, ☐ High blood pressure, ☐Edema (swelling of legs and/or ankles), ☐High cholesterol, ☐ Abnormal valves, ☐Heart enlargement, ☐History of heart attack, ☐Heart Failure, ☐ Arrhythmia , ☐Shortness of Breath

RESPIRATORY- ☐Cough, ☐Wheezing, Shortness of breath: ☐at rest, ☐at night, ☐with exertion, ☐Pain associated with breathing, ☐Asthma, ☐Exposure to asbestos, ☐History or tuberculosis

Have you ever had a tuberculosis test? ◯YES ◯NO Date_______________

GASTROINTESTINAL- ☐Nausea, ☐Vomiting, ☐Change in bowel habits, ☐Diarrhea, ☐Constipation, ☐Trouble swallowing, ☐Heart burn, ☐Abdominal pain, ☐Ulcer, ☐Gallbladder disease, ☐Hemorrhoids, ☐Hepatitis, ☐Jaundice, ☐Rectal problems, ☐Black or tarry stool, ☐Colon Polyps, ☐History of jaundice

GENITOURINARY- ☐Painful Urination, ☐Frequency, ☐Urgency, ☐Urinating at night, ☐Abnormal bleeding in urine, ☐Kidney stones, ☐Trouble starting or stopping urine stream, ☐Bladder infection, ☐Trouble controlling your bladder, ☐Sexually transmitted diseases

How many times do you urinate at night?_______________

HEMATOLOGICAL- ☐Easy bruising, ☐Transfusion Reactions, ☐Excessive bleeding, ☐Anemia

MUSCULOSKELETAL- ☐Arthritis, ☐Gout, ☐Joint pains, ☐Swelling and stiffness, ☐Muscle cramps, ☐ Back pain, ☐Neck pain, ☐Red or swollen joints, ☐Osteoporosis, ☐Loss of Height

Have you ever had a scan for osteoporosis? ◯Yes ◯No Date________________

PERIPHERAL VASCULAR- ☐Varicose veins, ☐Blood clots, ☐Leg pain, ☐Muscle cramps in arms or legs

NEUROLOGICAL- ☐ Right or Left Handed, ☐Frequent or severe headaches, ☐Fainting, ☐ Loss of consciousness, ☐ Seizure or Convulsion (Epilepsy), ☐ Spinning sensation (vertigo), ☐ Balance problems, ☐ Periods of lightheadedness, ☐ Difficulty walking, ☐ Numbness or tingling in arms or legs

NEUROPSYCHIATRIC- ☐Seizures,☐ Paralysis/paresis,☐ Extreme mood change,☐ Insomnia, ☐Anxiety,☐ Psychiatric care,☐ Suicidal ideations,☐Difficulty experiencing pleasure, ☐Emotional illness,☐Feelings of worthlessness or guilt

ENDOCRINE- ☐Heat/Cold intolerance, ☐Increased thirst, ☐ Abdominal pain, ☐High blood sugars, ☐Thyroid problems, ☐Reproductive problems, ☐Weak bones, ☐Abnormal electrolytes, ☐Sexual problems, ☐Difficulty concentrating, ☐ Any known gland problems

ALLERGIC/IMMUNOLOGIC- ☐Skin or other rashes, ☐Reactions to medications or foods

If any of the above symptoms require additional explanation, please do so here:

____

____

____

____

For Women Only:

Age of first menstrual cycle ________

Are your menstrual cycles regular?
○ Yes ○ No

If not, explain___________________________
____

Date of your last cycle___________________

Any pain during periods? ○Yes ○No

Have you gone through menopause?
____

At what age____ ○ Surgical ○ Natural

Number of pregnancies_________________

Number of children____________________

Number of miscarriages (if any)__________

Any sexual problems? (Lack of libido, etc.)__
____

Do you perform monthly breast exams?
○Yes ○No

Date of Last Mammogram_______________

Date of Last Pap Smear_________________

Have you ever had any of the following:
☐Abnormal Pap smear, ☐ Breast discharge,
☐Unusual vaginal bleeding or pain,
☐Unusual vaginal discharge? If yes, explain

____
____
____

Do you experience hot flashes?
○Yes ○No

Have you ever taken estrogen therapy?
○Yes ○No

Did your mother take DES (hormone) while pregnant with you? ○Yes ○ No

For Men Only:

Have you ever had any prostate problems?
○ Yes ○ No

Are you having urination at night?
○ Yes ○ No

Are you experiencing any difficulty with erections? ○Yes ○No

Do you get morning erections?
○ Yes ○ No

Do you have a low sex drive?
○Yes ○ No

Have you ever had any lumps in your testicles? ○ Yes ○No

Are you having pain during sexual intimacy?
○Yes ○ No

SOCIAL HISTORY

Marital Status (circle or check): ☐Single,
☐ Married, ☐ Significant Other, ☐Widowed,
☐ Divorced, ☐ None of Dr's Business

With whom do you live?_________________

Birthplace______________________________

Part of world you grew up in?____________
____

Education______________________________

Occupation_____________________________

Religion (optional)_____________________

Leisure Activities and Hobbies____________
____

HABITS

Smoking/ Tobacco Use: ○Yes ○No
Packs/day____ for # of _____ years

Year Quit_________

Alcohol Use: ○Yes ○No,
Daily Amount________________________
Do you feel this is a problem? ___________
____

Recreational or illicit drug Use: ○Yes ○No
If yes, specify___________________________

Caffeine Use: ____☐Coffee____☐Tea
Soda: # Cups Daily___

Do you have an advanced directive or power of attorney in place in the unlikely event of a sudden tragedy that would render you unable to make decisions?________________________

If you have any other questions or concerns for Dr. Bernard please list. Thank you for taking the time to complete this form!

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Signature ___________________________________ **Date**____________________________

If under 18 years of age please have legal guardian sign here:_____________________________