The Endocrine Clinic, P.C.

ADULT SELF ASSESSMENT

PAST MEDICAL HISTORY

Name: ______________________ Date: ______________

1. Past and Present Illness/Hospitalizations/Surgeries:
   Illness ______________ Year ________ Illness ______________ Year ________
   ______________ ________ ______________ ________
   ______________ ________ ______________ ________

1a. Do you have any metal in your body? ________ If yes, explain: ______________________

2. Medications currently taking (prescription & non-prescription) - Give dosage: ❑ None
   ______________ ______________ ______________
   ______________ ______________ ______________

3. Allergic or bad reaction to medication:
   ______________ ______________ ______________

FAMILY HISTORY

4. Family Diseases:

	Family Member		Family Member
❑ Heart Attack	______________	❑ Stroke	______________
❑ Diabetes	______________	❑ High Blood Pressure	______________
❑ Cancer	______________	❑ Thyroid problem	______________
❑ Kidney Disease	______________	❑ Obesity	______________
❑ Other:	______________	❑ Other:	______________

SOCIAL HISTORY

5. Smoking: ❑ Currently smoke? Packs per day: ________ Total years smoking: ________
   ❑ Stopped smoking? How long ago? ________ Total years smoking? ________
   ❑ Never smoked?

6. Alcohol consumption per week: Beer: ________ Wine: ________ Hard Liquor: ________
   Ever missed work from drinking: ❑ YES ❑ NO Ever hospitalized from drinking? ❑ YES ❑ NO

7. Drugs used regularly: ❑ Marijuana ❑ Barbiturates ❑ Amphetamines ❑ Opiates ❑ Cocaine

8. Exercise: ❑ YES ❑ NO
   Type: ________ Frequency: ________ Time: ________ Distance: ________

9. Social: ❑ Homemaker ❑ Retired ❑ Unemployed ❑ Disabled ❑ Student
   Employed/Occupation ______________ Hours at work/school ______________

MEDICAL SYSTEM REVIEW

10. Normal Weight ________ Present Weight ________

11. General Problems:
    ❑ Weight change ________ ❑ Excessive tiredness ❑ Fever/Chills
    ❑ Poor or inability to sleep ❑ Excessive nervousness ❑ Other: ________

12. Skin:
    ❑ Rashes ❑ Change in scalp hair________ ❑ Change in nails: ________
    ❑ Change in body hair:________ ❑ Other:________ ❑ Other: ________

13. Eye Problems:
    ❑ Wear eyeglasses or contacts ❑ Blurred vision ❑ Glaucoma
    ❑ Laser therapy ❑ Legal blindness ❑ Other: ________

(OVER)

MEDICAL SYSTEM REVIEW

14. Head, Ear, Nose and Throat Problems:
- ❑ Headaches
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Hoarseness (constant)
- ❑ Allergies
- ❑ Sinus drainage
- ❑ Dentures
- ❑ Thyroid Problems:____________
- ❑ Other: ______________________________

15. Respiratory Problems:
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ History of TB
- ❑ Other:______________________
- ❑ Other: ______________________________

16. Heart/Cardiovascular Problems:
- ❑ Chest pain with exertion
- ❑ Rheumatic fever
- ❑ Heart murmur
- ❑ Missed, skipped beats or heart fluttering
- ❑ Heart attack
- ❑ Stroke
- ❑ Lightheadedness when sitting or standing
- ❑ Leg pain when walking
- ❑ High cholesterol
- ❑ Other:_____________________________
- ❑ Other:______________________
- ❑ Other: ______________________________

17. Urinary Problems:
- ❑ Painful or burning when urinating
- ❑ Hesitation
- ❑ Too frequent urination
- ❑ Bladder or kidney infection
- ❑ Kidney stones
- ❑ Other: ______________________________
- ❑ Known kidney problems: ____

18. Blood Disorders:
- ❑ Low blood count
- ❑ Easy bruising
- ❑ Sickle cell disease
- ❑ Other:_____________________________
- ❑ Other:______________________
- ❑ Other: ______________________________

19. Neuromuscoskeletal Problems:
- ❑ Tingling or painful limbs
- ❑ Weakness
- ❑ Seizures
- ❑ Fractures
- ❑ Arthritis
- ❑ Pain
- ❑ Head injuries
- ❑ Foot problems
- ❑ Other: ______________________________

20. Stomach and Intestinal Problems:
- ❑ Belching
- ❑ Constipation
- ❑ Vomiting blood
- ❑ Feeling of fullness or discomfort in morning
- ❑ Diarrhea
- ❑ Nausea
- ❑ Bloody or black bowel movement
- ❑ Indigestion
- ❑ Pancreatitis
- ❑ Other:_____________________________
- ❑ Other:______________________
- ❑ Other: ______________________________

21. Liver Problems:
- ❑ Hepatitis
- ❑ Cirrhosis
- ❑ Jaundice
- ❑ Gallbladder trouble
- ❑ Other:______________________
- ❑ Other: ______________________________

22. Emotional/Social Problems:
- ❑ Past emotional problems/hospitalization?____
- ❑ Current emotional/social problems: ____

FOLLOWING QUESTIONS FOR WOMEN ONLY

23. Menstrual History: Age period started:______ Age period stopped:______ Hysterectomy: ❑ YES ❑ NO Age: ______

24. Gynecological Problems: ❑ Menstrual irregularities ❑ Post menopausal bleeding ❑ Vaginal discharge/infection
❑ Breast discharge - explain: ______________________________________ ❑ Date of last pap smear? ________

25. Gynecological Problems: Number of pregnancies:______ Number of miscarriages/stillbirths:______
Number of abortions:______ Number of livebirths greater than 8½ lbs:______

26. Pregnancy Problems: ❑ Excessive weight ❑ High blood pressure ❑ Toxemia
❑ Diabetes during pregnancy ❑ Other:____

FOLLOWING QUESTIONS FOR MEN ONLY

27. Genito-urinary Problems: ❑ Prostrate problem ❑ Sexual difficulties:______________ ❑ Impotence
❑ Other:____