

Name: \_\_\_\_\_ MR#: \_\_\_\_\_ Date: \_\_\_\_\_

**Filling out this form allows us to focus on special issues if needed during your office visit. Thanks!**

1. Has there been any Hospitalization, Surgery, Fracture or Major Illness since the last visit?  
 Yes       No
  
2. Have there been any **NEW** School, Family, or Social Problems since the last visit?  
 Yes       No
  
3. Any Family members with new onset of diabetes, heart attack, stroke, cancer, thyroid disease, osteoporosis, pituitary or other hormone related problems since your last visit?  
 Yes       No
  
4. Have there been any chronic problems (lasting more than two weeks) that have developed since the last visit?
 

Headaches, dizziness, double or blurred vision, rash or fever	<input type="radio"/> Yes	<input type="radio"/> No
Joint or Muscle Ache, Stiffness, Swelling or Redness	<input type="radio"/> Yes	<input type="radio"/> No
Fast Heart Rate, Sweating, Heat or Cold Intolerance	<input type="radio"/> Yes	<input type="radio"/> No
Chest Pain, Shortness of Breath, Chronic Cough or Wheezing	<input type="radio"/> Yes	<input type="radio"/> No
Diarrhea, vomiting, constipation, fullness, nausea	<input type="radio"/> Yes	<input type="radio"/> No
Frequent Urination, Excessive Thirst, Kidney Stones, Blood in Urine	<input type="radio"/> Yes	<input type="radio"/> No
Puberty Changes	<input type="radio"/> Yes	<input type="radio"/> No
Change in weight	<input type="radio"/> Yes	<input type="radio"/> No
New fatigue	<input type="radio"/> Yes	<input type="radio"/> No
Depression, Nervousness, Stress	<input type="radio"/> Yes	<input type="radio"/> No

For other chronic medications or therapy, please list them in this chart:  
 (Include vitamins, herbs, aspirin products, estrogens & contraceptives)

	MEDICATION	DOSE	HOW OFTEN?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

**PLEASE GIVE THIS SHEET TO THE FRONT DESK BEFORE YOU ARE CALLED BACK TO A ROOM. THE FRONT DESK WILL RETURN A COPY TO YOU, PLEASE GIVE THIS COPY TO THE NURSE.**

**PLEASE LET THE NURSE KNOW IF YOU NEED YOUR PRESCRIPTIONS REFILLED. We suggest you keep a list of medications with doses and frequency in your wallet or purse. Thanks again very much!**