APPOINTMENT DATE AND TIME : ______________________________

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Diabetes & Endocrinology Consultants, PC
611 N 35th St, Morehead City, NC 28557-3126

Medical History Questionnaire

Name ____________________________________ **Date of Birth** _______________

Referred By __________________ **Primary Care Physician** __________________

Reason for visit ____

List All Current Medical Problems and Date of Diagnosis ____________________

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List All Surgeries, Previous Hospitalizations, Serious Accidents and Year Occurred

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List All Pregnancies, Complications of Pregnancies, and Birth Weights of Babies

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List medications that you cannot take and what side-effect you had with each one

Name of Medication	Side-Effect

List all prescription and over the counter medications, vitamins, and other supplements you are currently taking (you may continue list on back of form)

Name	Dose	Frequency
Example Drug Name	*20mg*	*Twice a day*

Social History

Place of Birth: ________________________________ Marital Status: ______________________

Names of Children and Ages ____

Highest Level of Education Completed or grade you are in now.__________________________

Occupation (if retired list previous occupation)____

Recent Stresses or Major Life Changes ____

Cigarettes Per Day / Years You Have Smoked /Year You Quit __________________________

Amount of Snuff/ Chewing Tobacco Used Per Day ____________________________________

Amount and Type of Alcohol per Week ____

Amount and Type of Exercise per Week ____

Under Age 18 only

Weight at birth: _________ Age started puberty: _________ Age started periods: ________

Complications at birth: ____

Behavioral problems in school: ____

Family History

Do Any Of Your Close Relatives Have The Following Conditions?

Condition	***Check if yes***	***Which Relative (s)?***
Cancer of the breast		
Cancer of the colon		
Cerebrovascular disease (Stroke)		
Diabetes		
Heart Disease		
High Cholesterol		
Hypertension (high blood pressure)		
Kidney Stones		
Obesity		
Osteoporosis		
Thyroid Disease		

	Existing Medical Problems	***Cause Of Death***	***Age at Death***
Father			
Mother			

Check yes or no to the following symptoms

	YES	NO		YES	NO
GENERAL SYMPTOMS			Shortness of breath at rest		
Decreased activity			Shortness of breath on exertion		
Decreased energy			Swelling (edema)		
Weight gain			Palpitations		
Weight loss			Fast heart rate		
EYES			**GASTROINTESTINAL**		
Change in vision			Abdominal pain		
Change in peripheral vision			Bloating		
Cataracts			Constipation		
Droopy eyelids			Diarrhea		
Dry eyes			Feeling full before end of meal		
Glaucoma			Excessive gas		
Macula degeneration			Heartburn		
			Hepatitis		
EAR, NOSE AND THROAT			Indigestion		
Problems with hearing			Loss of appetite		
Ringing in ears (tinnitus)			Nausea		
Vertigo			Vomiting		
Nosebleeds					
Altered sense of smell			**MALES ONLY**		
Nasal congestion			Change in sex drive		
Snores			Unable to maintain erection		
Problems with teeth			Unable to have an erection		
Dry mouth			Prostate enlargement		
Mouth ulcers			Change in urine stream		
Difficulty swallowing					
Hoarseness			**FEMALES ONLY**		
Throat pain			Abnormal menstrual bleeding		
			Heavy periods		
PULMONARY			Irregular periods		
Asthma			Cysts on ovaries		
Emphysema			Painful periods		
Cough			Premenstrual symptoms		
Wheezing			Decreased sex drive		
			Vaginal infections		
CARDIOVASCULAR			Hot flashes		
Chest discomfort			Night sweats		
Chest pain			Vaginal dryness		
Cold hands and feet			Leakage of urine		

	YES	NO		YES	NO
MUSCULOSKELETAL			**BREAST**		
Arthritis			Breast discharge		
Joint pain			Breast soreness		
Restriction of movement			Enlargement of breasts		
Stiffness					
Swelling of joints			**PSYCHIATRIC**		
Muscle cramps			Change in personality		
Muscle pain			Depression		
Muscle weakness			Eating disorder		
			Irritability		
NEUROLOGICAL			Hostility		
Difficulty walking			Hyperactivity		
Difficulty with balance			Increased nervousness		
Concentration problems			Mood swings		
Confusion/disorientation			Restlessness		
Problems with coordination			Excessive sleepiness		
Dizziness			Difficulty falling asleep		
Fainting			Difficulty staying asleep		
Headache					
Lightheadedness			**ENDOCRINE**		
Memory loss			Excessive body hair		
Paralysis			Excessive facial hair		
Seizures			Deepening of voice		
Burning			Excessive sweating		
Pins and needles			Excessive hunger		
Tingling			Excessive thirst		
Numbness			Excessive urination		
Tremor			Eyes sticking out		
			Increased body odor		
SKIN			Bone fractures		
Abnormal sensitivity to sunlight			Change in height		
Blisters			Bone density in the last 2 years		
Change in skin color			Heat intolerance		
Change in hair			Cold intolerance		
Change in nails			Change in size of hands or feet		
Dry skin					
Hives			**HEMATOLOGICAL**		
Itching in skin			Anemia		
Lumps in skin			Bleeding disorder		
Painful area in skin			Bruises easily		
Rash			Painful lymph nodes		
Acne			Swollen lymph nodes		