Houston Endocrine Center

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Medical History

Name: _____ Date of Birth _____

Family History: ☐Diabetes ☐High Blood Pressure ☐Stroke ☐Heart Disease ☐Arthritis ☐Cancer ☐Other: Please List:

_____

Social History: Occupation: _____

Do you smoke? Yes No (circle one) If so, How often? _____

Do you consume alcohol? Yes No (circle one) If so, How often? _____

Have you used social drugs in the past? (Marijuana, etc.) Yes No (circle one)

Past Medical History: __

☐Measles ☐Chicken Pox ☐Tuberculosis ☐Migraines ☐Diabetes
☐Glaucoma ☐Cataracts ☐Asthma ☐Heart Attack ☐Stroke
☐Hepatitis ☐Gall Stones ☐Cancer ☐Mumps ☐Kidney Disease
☐Thyroid Disease ☐Rheumatic Fever ☐Hypertension ☐Seizures/Epilepsy
☐Depression/ Anxiety ☐Sexually Transmitted Disease ☐Degenerative Joint Disease
☐Rheumatoid Arthritis/Gout ☐Emphysema/Chronic Bronchitis

Please list all surgeries _____

_____

Please list all hospitalization _____

_____

Please list all allergies _____

_____

PLEASE CHECK ALL SYMPTOMS BELOW

☐Heart burn/stomach pain	☐Excessive Weight Loss	☐Muscle weakness
☐Excessive Weight Gain	☐Nausea/ Vomiting	☐Tender points in muscle
☐Headache	☐Gastric ulcers	☐Insomnia
☐Double Vision	☐Constipation	☐Hoarseness
☐Sinus Trouble	☐Diarrhea	☐Swelling of ankles/legs
☐Hay Fever/ Allergies	☐Frequent urination	☐Easy Bruising
☐Chest Pain	☐Burning during urination	☐Blood in Sputum
☐Palpitations	☐Blood in Urine	☐Joint Pain
☐Dizziness	☐Excessive Thirst	☐Joint Swelling
☐Fainting Spells	☐Depression/Anxiety	☐Numbness
☐Weakness	☐Dryness/ Redness of Eyes	☐Skin Rash/ sores
☐Chronic Cough	☐Joint Stiffness	☐Back Pain
☐Wheezing	☐Shortness of Breath	☐Fever

List of medications _____

_____

_____