

Academic Endocrine Metabolism & Nutrition, Inc.

2001 Gary Avenue, Suite #240
Wheaton, IL 60187

Voice Telephone: 630/416-4501
Fax: 630/416-4504
Emergency: 630/901-1911

2007 95th Street, Suite #101
Naperville, IL 60564

www.academicendocrinology.com

NEW PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

1. Reason for Visit: _____

2. Current Medications and Dosages: _____

3. Allergies to Medications and Reactions: _____

4. Past Medical History & Other Health Problems: _____

5. Previous Surgeries & Dates: _____

6. Past & Present Treatment for Question #1. _____

7. Family History of:	Thyroid Conditions	Yes _____	No _____
	Diabetes	Yes _____	No _____
	Growth Problems	Yes _____	No _____
	*Other Endocrine-related Problems	Yes _____	No _____

*If yes, please describe: _____

8. History of Alcohol, Drug, or Tobacco Use: Yes _____ No _____

9. History of Psychosocial Problems Yes _____ No _____

If yes, please describe: _____

Please bring with you a copy of any medical records or lab work previously done relating to the reason for your visit. For an adult, this will include x-rays, blood tests, & surgical procedures etc. For a child, this will include all of the above information in addition to a copy of the child's growth chart.

*****Please bring this completed form with you to your visit.**

HISTORY QUESTIONNAIRE

COMPLETED BY: _____ [STAFF] [PATIENT] [PHYSICIAN] ON: ___/___/___

NAME: _____ [MALE] [FEMALE] AGE: _____ DATE OF BIRTH: ___/___/___

S O C I A L	Marital Status: [single] [married] [widowed ___/___/___] [divorced ___/___/___]	
	Occupation: [retired] [active] _____	
	Do you: <i>[Please circle No or Yes and explain if Yes]</i>	
	Live with others	[no] [yes] → who: _____
	Have children	[no] [yes] → # living _____, # deceased _____ → from: _____
	Get exercise	[no] [yes] → hours per week: _____
Use illegal drugs	[no] [yes] → _____	
Use alcohol	[no] [yes] → ounces per day _____	
Smoke	[no] [yes] → packs per day _____ stopped _____	

P A S	Have you ever had:	
	Surgery	[no] [yes] → date: _____ hospital: _____ for: _____
	Blood transfusion	[no] [yes] → date: _____ hospital: _____ for: _____
	An illness	[no] [yes] → date: _____ hospital: _____ for: _____

S T M E D I C A L	Problems for which you have seen a physician or have been treated for:			
			Medications prescribed	Currently taking
	Diabetes	[no] [yes] →	_____	→ [no] [yes]
	Cancer	[no] [yes] →	_____	→ [no] [yes]
	Tumor/lesion	[no] [yes] →	_____	→ [no] [yes]
	Scarlet fever	[no] [yes] →	_____	→ [no] [yes]
	COPD	[no] [yes] →	_____	→ [no] [yes]
	Blood pressure	[no] [yes] →	_____	→ [no] [yes]
	Heart problem	[no] [yes] →	_____	→ [no] [yes]
	Infections	[no] [yes] →	_____	→ [no] [yes]
	Pain	[no] [yes] →	_____	→ [no] [yes]
	Nervousness	[no] [yes] →	_____	→ [no] [yes]
Arthritis	[no] [yes] →	_____	→ [no] [yes]	
Others _____		_____	→ [no] [yes]	

C A L	You have any allergies / reactions to:	
	Food(s)	[no] [yes] → _____
	Penicillin	[no] [yes] → _____
	Other antibiotics	[no] [yes] → _____
	Pain medications	[no] [yes] → _____
	Aspirin	[no] [yes] → _____
Others	→ _____	

F A M I L Y	Do any of your blood relatives have or have had any of these diseases or			
	Do any other problems run in the family:			
	Diabetes	[no] [yes] →	Type _____	TB [no] [yes]
	Cancer	[no] [yes] →	Location: _____	Thyroid disease [no] [yes]
	Tumor/lesion	[no] [yes] →	Location: _____	High blood pressure [no] [yes]
	Heart problem	[no] [yes] →	Type _____	Stroke [no] [yes]
	Other _____			
	Your Father:	[living] [died] ___/___/___ →	of _____	
	Your Mother:	[living] [died] ___/___/___ →	of _____	
	Your Brothers:	[living] [died] ___/___/___ →	of _____	
Your Sisters:	[living] [died] ___/___/___ →	of _____		

HISTORY QUESTIONNAIRE

COMPLETED BY: _____ STAFF PATIENT PHYSICIAN ON: _____

NAME: _____ MALE FEMALE AGE: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

POSITIVE RESPONSE = **CIRCLE** AND THEN EXPLAIN; FOR EXAMPLE: LOCATION

HAVE YOU RECENTLY NOTICED <small>Constitutional Systems</small>	→	Change in Appetite	Change in Weight	Night sweats	Fatigue
DO YOU HAVE <small>Skin</small>	→	Sores that don't heal	Changes in skin moles		
DO YOU HAVE <small>All/Imm</small>	→	Seasonal allergies			
HAVE YOU HAD RECENTLY <small>Ears – Nose – Mouth - Throat</small>	→	Change in hearing	Sinus problems	Trouble with balance	
		Difficulty swallowing	Difficulty sleeping		
HAVE YOU RECENTLY HAD <small>Eyes / Head</small>	→	Loss of vision	Severe headaches	Blackouts or falling	
DO YOU HAVE <small>Redp</small>	→	Shortness of breath	Frequent coughs	Wheezing	
DO YOU HAVE <small>CV</small>	→	Chest pain	Swollen ankles	Inflamed veins	
DO YOU HAVE <small>GI</small>	→	Indigestion	Heart burn	Nausea	Abdominal pain
		Change in bowel habits	Diarrhea	Constipation	Black stools
DO YOU HAVE <small>GU</small>	→	Painful urination	Blood in urine	Frequent urination at night	
		Decreased force/flow	Vaginal discharge	Last pap smear: _____	
DO YOU HAVE <small>Endo</small>	→	Lumps in your breasts	Breast discharge	Last mammogram: _____	
DO YOU HAVE <small>Musclosk</small>	→	Back pain	Pain in joints	Stiffness	
DO YOU FEEL <small>Neuro</small>	→	Tingling	Loss of speech	Numbness of arms / legs	
DO YOU FEEL <small>Psych</small>	→	Anxious	Depressed		
DO YOU <small>Heme/Lymph</small>	→	Bruise easily	Swollen glands	Bleed a lot	

Do you have any other signs symptoms or problems other than above? No Yes

Please explain:

Reviewed last : by / date _____