

Arizona Endocrinology Center
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Medical History

Name: _____ DOB: _____

Personal Medical History: Check if you have had any of these medical problems in the past.

Major illness

Anemia Y N

Cancer Y N Type: _____

Chronic Lung Disease Y N

High blood Pressure Y N

Diabetes Y N Type: _____

Migraines Y N

Hypothyroid Y N

Stroke Y N

Hyperthyroid Y N

Heart Disease Y N

Osteopenia Y N

Hepatitis Y N

Osteoporosis Y N

Other: _____

Past Surgical History: No past surgical history

<u>Year</u>	<u>Surgery</u>	<u>Complications?</u>

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Allergies:

<u>Medication</u>	<u>Reaction</u>	<u>Medication</u>	<u>Reaction</u>

Social History

Do you drink alcohol? Yes No If yes, Social Drinker Daily if yes, how many drinks per week? _____

Do you use recreational drugs? Yes No If yes, what kind? _____

Do you use tobacco? Yes No If yes, Current every day _____ Current some days _____

Former _____ Never _____

If current, how many cigarettes a day? _____

If an occasional smoker - Please describe: _____

Family Medical History

<u>Member of family</u>	<u>Diabetes</u>	<u>Heart Disease</u>	<u>Cancer</u>	<u>Thyroid Disease</u>
Grand father				
Grandmother				
siblings				
children				
Father				
Mother				

