Arizona Endocrinology Center

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Medical History

Name: _____DOB:_____

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

Major illness

Anemia Y☐ N☐

Cancer Y☐ N☐ _____

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

Year	Surgery	Complications?

Allergies:

Medication	Reaction	Medication	Reaction

Social History

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

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

Do you use tobacco? o Yes o 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

Member of family	Diabetes	Heart Disease	Cancer	Thyroid Disease
Grand father				
Grandmother				
siblings				
children				
Father				
Mother				

Current Medications: ☐ None If there is not sufficient space please attach copy of medications list to this form.

Prescription and non-prescription medicine, vitamins, home remedies, birth control pills:

Medication	Dosage (mg, units)	Frequency