Endocrinology of Central Pennsylvania, LLC

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NEW PATIENT HISTORY FORM (Part of Medical Record) Please Fill out all sections

Name _____ Date of Birth _____ Family Physician _____

Drug Allergies _____ Date of Visit _____

Past Medical History: Do **you** have any history of the following problems ? *Please Circle **Yes** (Y) or **No** (N)

Diabetes	Y	N	High Blood Pressure	Y	N			
Heart Disease	Y	N	Cancer	Y	N			
Arthritis	Y	N	Thyroid Problems	Y	N	Liver Problems	Y	N
High Cholesterol	Y	N	Osteoporosis	Y	N	Stomach Ulcer	Y	N
Kidney Disease	Y	N	Congestive Heart Failure	Y	N			
Kidney Stones	Y	N	Depression	Y	N	Other _____		

Any surgeries in the past? List all major surgeries _____

Family History: Do you have any Family members with any of the following problems? *Please Circle **Yes** (Y) or **No** (N)

Diabetes	Y	N	High Blood Pressure	Y	N	High Cholesterol	Y	N
Heart Disease	Y	N	Thyroid Problems	Y	N	Cancer	Y	N
Arthritis	Y	N	Osteoporosis	Y	N	Kidney Stones	Y	N
Kidney Disease	Y	N				Other _____		

Social History: *Please Circle **Yes** (Y) or **No** (N)

Currently Smoking Y N If yes, how much _____ Years _____
Past Smoker Y N Quit when _____
Alcohol Y N How much daily _____ Social drinker _____
Married _____ Single _____ Widowed _____ Divorced _____ Children _____ Occupation _____

DO YOU HAVE ANY OF THESE SYMPTOMS AT PRESENT *Please Circle **Yes** (Y) or **No** (N)

Constitutional:

Any Pain	Y	N	(1 = Mild / 10 = Severe) _____					
Tiredness	Y	N	Weight Loss	Y	N	Weight Gain	Y	N
ENT:								
Sinus Congestion	Y	N	Ear Problems	Y	N	Headaches	Y	N
EYES								
Vision Changes	Y	N	Drying/Itching in Eyes	Y	N			
CVS								
Chest Pain	Y	N	Swelling in Legs	Y	N	Palpitations	Y	N
Respiratory								
Cold/Cough	Y	N	Shortness of Breath	Y	N	Blood in Cough	Y	N
GI								
Constipation	Y	N	Bloating	Y	N	Nausea	Y	N
Diarrhea	Y	N	Heart Burn	Y	N			
GU								
Difficulty Urination	Y	N	Frequent Urination	Y	N	Impotence	Y	N
CNS								
Numbness	Y	N	Tingling	Y	N	Burning	Y	N
Muscle Weakness	Y	N	Dizziness	Y	N	Seizures	Y	N
PSYCH								
Depression	Y	N	Anxiety	Y	N			
SKIN								
Skin Rashes	Y	N	Bruising	Y	N	Excessive Sweating	Y	N
For Females Only:	Last Period _____		Irregular Menses	Y	N	Nipple Discharge	Y	N
For Males Only:			Erection Problem	Y	N	Impotence	Y	N

Patient Signature _____ Physician Signature _____
Dr Anupam Srivastava