

**OVERLAKE INTERNAL MEDICINE ASSOCIATES  
CONFIDENTIAL MEDICAL HISTORY – ENDOCRINOLOGY**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Record #: \_\_\_\_\_

Age: \_\_\_\_\_ Referred by (if any): \_\_\_\_\_

Please answer all questions. If you do not know the answer, or do not understand the question, insert a question mark in the space.  
Please leave no blanks.

**What brings you to see Dr. Mystkowski today?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list any current medical problems:**

Problem	Date of Onset

**Current Medications:**

Name of Medicine	Strength of Each Dose	How Often Taken	When Medication Started

**Do you have any medication allergies/intolerances? If so, to what?** \_\_\_\_\_  
\_\_\_\_\_

**For patients with Diabetes, please answer the following:**

- 1) When were you diagnosed? \_\_\_\_\_ 2) When were you switched to Insulin? \_\_\_\_\_  
3) Have you had any complications related to Diabetes such as, kidney problems \_\_\_\_\_, laser surgery for the eyes \_\_\_\_\_, nerve problems \_\_\_\_\_, other \_\_\_\_\_? 4) Any history of heart disease \_\_\_\_\_?

**Family Health:**

Relation	Age if Alive	Age at Death	State of Health or Cause of Death
Mother			
Father			
Brothers and Sisters			
Spouse			
Children			

**Personal History:**

- 1) What is your occupation? \_\_\_\_\_
- 2) Education completed? Grade school \_\_\_\_\_, High school \_\_\_\_\_, College \_\_\_\_\_, Graduate school \_\_\_\_\_ Years of education \_\_\_\_\_
- 3) Marital status? Married \_\_\_\_\_, Single \_\_\_\_\_, Divorced \_\_\_\_\_, Widowed \_\_\_\_\_, Engaged \_\_\_\_\_, Co-habiting \_\_\_\_\_
- 4) What is your spouse/partner's name? \_\_\_\_\_ 5) Number of children? \_\_\_\_\_
- 6) Who lives at home with you? \_\_\_\_\_
- 7) What do you do for enjoyment? \_\_\_\_\_

**Review of Symptoms:** Please check any symptom you have/experience

**Constitutional**

- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained fatigue/weakness
- Tired when I wake up/snoring

**Eyes**

- Change in vision

**Ears/Nose/Throat/Mouth**

- Difficulty hearing/ringing in ears
- Hay fever/allergies/congestion
- Trouble swallowing

**Cardiovascular**

- Chest pains/discomfort, especially with exertion
- Palpitations
- Pain in the legs with walking

**Breast/skin**

- Breast lump
- Nipple discharge
- Rash
- Itching

**Respiratory**

- Cough/wheeze
- Coughing up blood
- Trouble breathing

**Psychiatric**

- Anxiety/stress
- Sleep problems

Are there any other symptoms you might be concerned about? \_\_\_\_\_

\_\_\_\_\_

**Gastrointestinal**

- Heartburn/reflux
- Blood or change in bowel movement
- Nausea/vomiting/diarrhea/constipation
- Pain in abdomen

**Genitourinary**

- Irregular menstrual cycles/periods
- Frequent urination
- Waking up at night to urinate

**Musculoskeletal**

- Muscle/joint pain
- Recent back pain

**Neurological**

- Numbness or tingling of hands or feet
- Memory loss
- Fainting

**Blood/Lymphatic**

- Unexplained lumps
- Easy bruising/bleeding

\_\_\_\_\_  
Patient Signature or Signature of Patient Representative

\_\_\_\_\_  
Relationship, if not signed by patient