

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? _____
- 4) What is your spouse/partner's name? _____ 5) Number of children? _____
- 6.) Do you smoke? Y / N If yes, for how long? _____ If you have quit smoking, how long ago did you quit? _____
- 7.) How many alcoholic drinks do you consume in a typical week? _____
- 8) Who lives at home with you? _____
- 9) 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