Kernodle Clinic

Department of Endocrinology

New Patient Health History Questionnaire

Patient Name: ________________________________ Date: ____/____/_____

Contact phone: _______-_______-________

Family contact name: ______________________________ phone: _______-_______-________

State briefly the problem that brought you to the doctor today:

____

____

Primary Care Provider (include the address and telephone number):

____

____

Please list all the medical conditions you are currently being treated for:

____

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Please list all the surgeries you have had and the year of the surgery:

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List all medications you take routinely, along with the doses:

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If you have diabetes, provide the name of your eye doctor ______________________________

When was your last dilated eye exam? ____________________________

Do you have diabetic retinopathy? Yes / No **If yes, have you had laser therapy?** Yes / No

Do you have any drug allergies? Yes / No

If yes, then please list them: ____

Please turn page over and complete the back side also.

Do any of the following diseases run in your FAMILY? Circle if Yes.
Diabetes • Heart disease • Heart attacks • High blood pressure • Stroke
Cancer –Type ___________________________________ • Kidney Disease
Overactive thyroid disease • Underactive thyroid disease (hypothyroidism) • Thyroid cancer

Marital Status: Single • Married • Divorced • Widowed • Separated

Do you smoke cigarettes? Yes / No

If **Yes**, how many cigarettes per day? ______ How many packs per day? _______________
Have you ever smoked cigarettes? Yes / No If Yes, when did you stop? _____________
Do you drink alcohol? Yes / No If **Yes**, how much daily? ___________________________
Are you, or could you be pregnant? Yes No Date of last menstrual period? __________

If you have any of the following problems, please circle them:

Fever	Weight Gain	Weight Loss
Blurred Vision	Fatigue	Headaches
Neck pain	Neck Swelling	Difficulty with Swallowing
Chest Pain	Palpitations	Nipple discharge
Short of breath	Cough	Nausea / Vomiting
Abdominal Pain	Diarrhea	Constipation
Blood in Stool	Numbness in Feet	Pain in Feet
Pain With Urination	Urinating Frequently	Blood in Urine
Leg Swelling	Easy Bruising	Rash

Irregular menstrual periods   Concerns About Sexual Function