NAME _____

DATE OF BIRTH_____/_____/_____

TODAY'S DATE _____

Have you had a foot exam in the past year?
☐Y ☐N
If so, where? _____

Have you had an eye exam in the past year?
☐Y ☐N
If so, where? _____

Do you have any allergies or reactions to medications? Please list:
_____
_____
_____
_____

Do you take any of the following:
☐ Calcium
If so, what dose and how many times a day?
_____
☐ Vitamin D
If so, what dose? _____

FAMILY HISTORY

Does anyone in your family have any of the following? If so, please list relationship

☐ Thyroid disease
Relationship _____
☐ Thyroid cancer
Relationship _____
☐ Diabetes on oral medications?
Relationship _____
☐ Diabetes on Insulin
Relationship _____
☐ Diabetes diagnosed high school or younger
Relationship _____
☐ Autoimmune disease such as Hashimoto's
Relationship _____
☐ Thyroiditis
Relationship _____
☐ Rheumatoid arthritis
Relationship _____
☐ Vitiligo, etc.
Relationship _____
☐ Calcium disorder (high calcium, low calcium etc)
Relationship _____
☐ Pituitary or Adrenal Disease
Relationship _____

REVIEW OF SYSTEMS

Please check any symptoms you have had in past 3 months:

General

☐ Weight loss
☐ Weight gain
☐ Fatigue
☐ Fever or chills
☐ Sweats
☐ Weakness
☐ None of the above

Eyes

☐ Decreased Vision
☐ Pain
☐ Redness
☐ Itchy Eyes
☐ Blurry vision
☐ Double vision
☐ None of the above

Ears/Nose/Throat

☐ Decreased hearing
☐ Ringing in ears
☐ Earache or Drainage
☐ Stuffiness
☐ Discharge
☐ Nosebleeds
☐ Swallowing difficulties
☐ Sinus pain
☐ Sore throat
☐ Hoarseness
☐ Lump in neck
☐ None of the above

Cardiovascular

☐ Palpitations
☐ Shortness of breath
☐ Difficulty breathing lying down
☐ Swelling
☐ Sudden awakening from sleep with shortness of breath
☐ None of the above

Respiratory

☐ Cough
☐ Sputum (color and amount) _____
☐ Shortness of breath
☐ Wheezing
☐ Congestion
☐ None of the above

Gastrointestinal

☐ Change in appetite
☐ Nausea
☐ Vomiting
☐ Constipation
☐ Diarrhea
☐ None of the above

Skin and Breasts

☐ Rash
☐ Itching
☐ Dryness
☐ Color changes
☐ Hair and nail changes

Breasts

☐ Pain
☐ Discharge
☐ None of the above

Neurological

☐ Headache
☐ Confusion
☐ Numbness and Tingling (location): _____
☐ None of the above
☐ Tremor
☐ Dizziness

Genitourinary

☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine (hematuria)
☐ Nocturia ☐ Irregular Menses
☐ Change in Libido
☐ None of the above

Psychiatric

☐ Nervousness
☐ Depression
☐ None of the above
☐ Insomnia
☐ Stress

Endocrine

☐ Hot Flashes
☐ Excessive Thirst
☐ None of the above
☐ Heat Intolerance
☐ Cold Intolerance

Hematologic

☐ Ease of bruising
☐ Ease of bleeding
☐ Swollen lymph nodes
☐ None of the above

Musculoskeletal

☐ Recent falls
☐ Fracture of bones
Which bone and when? _____
☐ None of the above

Allergic and Immunologic

☐ Itching
☐ Rash or Hives
☐ Lymph node swelling in neck