Patient Health History

Pt. Name:____

Social History

Occupation: Retired / Active (if active what type of work): ____________________

Please circle yes or no to the following, explain if yes:

Live with others	Yes	No	Who: ____________________
Have children	Yes	No	
Get exercise	Yes	No	If yes, # hours/week
Use alcohol	Yes	No	If yes, # of drinks per day or week ____________
Smoke	Yes	No	If yes, packs per day ________ Stopped? ________

Past Medical History

Have you ever had: **Year/Details if known**

Diabetes	Yes	No	____________
Borderline diabetes	Yes	No	____________
Gestational diabetes	Yes	No	____________
Hypertension	Yes	No	____________
High Cholesterol	Yes	No	____________
Diabetic eye/retina problems (retinopathy)	Yes	No	____________
Heart problem/Heart attack	Yes	No	____________
Neuropathy	Yes	No	____________
Low/High thryoid levels	Yes	No	____________
Thyroid nodules/Cancer	Yes	No	____________
Pituitary problems	Yes	No	____________
Cancer	Yes	No	____________
Adrenal problem	Yes	No	____________
Thyroid or pituitary surgery	Yes	No	Details/Year ____________

Have you ever had Radioactive Iodine Treatment Yes No Year ________

Have you had any of the following (please circle) Osteoporosis Osteopenia low bone density

Bone density test Yes No Year

Past radiation treatments of any kind? Yes No Year ________

Other Medical Problems: (please write in)

Surgeries Yes No List with year ____________________

Do you have any allergies/reactions to medications? Yes No If yes, which ones:

Family History

Do any of your blood relatives have or have had any of these diseases or do any other problems run in the family?

Diabetes	Yes	No	Type I or II ________	Early Menopause	Yes	No
Cancer	Yes	No	Which kind ________	Thyroid Disease	Yes	No
Heart Problem	Yes	No		High blood pressure	Yes	No
Stroke	Yes	No				

Your Father	Living	Died	At what age: ________	Of what: ________
Your Mother	Living	Died	At what age: ________	Of what: ________
Your brothers	Living	Died	At what age: ________	Of what: ________
Your sisters	Living	Died	At what age: ________	Of what: ________

Over please -->