Nancy Curosh, M.D.
Endocrinology

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Patient Medical History:

Patient Name: _____ **Birthdate:** _____

Referring Physician: _____

Reason for Appointment: _____

Patient Allergies: _____

Allergies to Medications: _____

List all surgeries with dates:

Surgery	Date	Surgery	Date

List other hospitalizations with dates:

Hospitalization	Date	Hospitalization	Date

Medications (List ALL medications you are taking regulary with doses, including non-prescription & vitamins):

Social and Family History:

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Who lives with you? _____

Occupation: _____ **Education:** _____

Have you ever smoked regularly? ◯ Yes ◯ No **Do you smoke currently?** ◯ Yes ◯ No

On average, how much alchohol do you drink each week? _____

Is there a history of any of the following in your famiy?

☐ Diabetes ☐ Thyroid problems

☐ Heart disease ☐ High blood pressure ☐ Cholesterol problems ☐ Cancer

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Patient Name: _____

Date of Birth: _____

Social Security No.: _____

Social and Family History (continued):

	Present Age	Age at Death	Health Status or Cause of Death
Father			
Mother			
Brothers/Sisters			
Children			

Check if you have been or are currently being treated for any of the following:

- ☐ Diabetes of high blood sugar
- ☐ Heart disease
- ☐ Foot ulser
- ☐ High blood pressure
- ☐ High cholesterol level
- ☐ Kidney stones
- ☐ Angina or chest pain
- ☐ Thyroid problem
- ☐ Asthma

Check any of the following conditions that apply to you:

- ☐ Excessive tiredness
- ☐ Marked weight change
- ☐ Excessive anxiety
- ☐ Problems with sleep
- ☐ Headaches which are new or severe
- ☐ Dizzy spells or passing out
- ☐ Balance problems
- ☐ Hair loss
- ☐ Excessive body hair
- ☐ Skin changes
- ☐ Change in vision
- ☐ Double vision
- ☐ Change in hearing
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Breast lump or discharge
- ☐ Chest pain or pressure
- ☐ Shortness of breath
- ☐ Heart beating rapidly or skipping
- ☐ Persistent cough
- ☐ Persistent nausea or vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Blood in stool
- ☐ Pain or Burning passing urine
- ☐ Difficulty emptying your bladder
- ☐ Frequent urination
- ☐ Muscle or joint pains
- ☐ Numbness or tingling in your feet
- ☐ Swelling in your feet or ankles

MEN'S CONDITIONS:

- ☐ Difficulty maintaining an erection
- ☐ Change in urine stream

WOMEN'S CONDITIONS:

- ☐ Recent change in menstrual cycle

Last menstrual period: _____

Number of pregnancies: _____

Number of miscarraiges: _____

Number of births: _____