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JOHNS HOPKINS MEDICINE
JOHNS HOPKINS COMMUNITY PHYSICIANS

# ENDOCRINE & METABOLIC HEALTH HISTORY

## A. PERSONAL INFORMATION

Name: Date of Birth: Today's Date:

## B. REASON FOR CONSULTATION

Please indicate the reason for your visit or your concerns or questions:

## C. GENERAL MEDICAL INFORMATION - PLEASE √ (DO YOU **OR** SOMEONE IN YOUR FAMILY HAVE?)

| CONDITION | YES | IN FAMILY | CONDITION | YES | IN FAMILY |
|---|---|---|---|---|---|
| High Blood Pressure | | | GERD/Hiatal Hernia | | |
| High Cholesterol | | | Liver Disorder | | |
| High Triglycerides | | | Gall Bladder Disease | | |
| Diabetes Mellitus | | | Intestinal Disorders | | |
| Heart Attack | | | Kidney Stones | | |
| Angina/Heart Disorder | | | Other Kidney/Bladder | | |
| Stroke/TIA | | | Arthritis | | |
| Seizures/Convulsions | | | Anemia | | |
| Migraine Headaches | | | Cancer | | |
| Other Neurological Disorder | | | Breast Problems | | |
| Asthma | | | Prostate Problems | | |
| Emphysema/Bronchitis | | | Glaucoma | | |
| Other Lung Disorder | | | Other Eye Disorders | | |
| Obstructive Sleep Apnea | | | Rashes or Other Skin Disorder | | |

## ENDOCRINE CONDITIONS - PLEASE √ (DO YOU **OR** SOMEONE IN YOUR FAMILY HAVE?)

| CONDITION | YES | IN FAMILY | CONDITION | YES | IN FAMILY |
|---|---|---|---|---|---|
| Pituitary | | | Pancreas | | |
| Thyroid | | | Ovaries | | |
| Adrenal Glands | | | Testes | | |
| Parathyroid Glands | | | | | |

Please give any details if any conditions are marked "Yes."

## D. MEDICATIONS: List current medications and dosages, including over the counter medications and supplements.

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Name: _____ Date of Birth: _____

| E. PAST SURGERIES OR PROCEDURES | | | |
|---|---|---|---|
| Surgery/Procedure | Date | Surgery/Procedure | Date |
| | | | |
| Thyroid | | Coronary Bypass | |
| Adrenal | | Stents | |
| Pancreas | | Bariatric | |
| Hysterectomy | | Other | |

| F. ALLERGIES |
|---|
| MEDICATIONS/DRUGS: X-RAY DYE: YES / NO |

| G. SOCIAL HISTORY |
|---|
| Tobacco: Y / N Amount_____ Alcohol: Y / N Amount: _____ |
| Exercise: Y / N Kind: _____ |

**Please complete this next section only if you have diabetes.**

| |
|---|
| In what year were you diagnosed with diabetes? How old where you? |
| Have you ever had any of the following diabetes-related complications? Please check: √<br>□ Diabetic eye disease? □ Nerve problems (numbness/tingling)?<br>□ Kidney problems or protein in your urine? □ Erectile dysfunction?<br>□ Foot ulcers or deformities? □ Delayed stomach emptying? |
| If you take insulin, what year did you start? |
| What diabetes medicines have you been on in the past? |
| Do you check your blood sugars at home? Y / N How often?<br>If you check them, what are they running?<br>Fasting: After meals:<br>Pre-lunch: Before bedtime:<br>Pre-dinner:<br>Are you having any low blood sugars, less than 70? Y / N What time of day/night? |
| When was your last diabetes eye exam? |
| Have you gone to any diabetes or nutrition classes? Y / N |