

MEDICAL HISTORY Please complete to the best of your ability.

Do you or have you ever had any of the following problems?

	Yes	No	Don't know
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, any complications (eye, kidney, nerve or foot problems)? _____			
If yes, date of last eye appointment? _____			

Heart disease

High blood pressure

High cholesterol

Thyroid disease

If yes, what type? (low or high thyroid levels, goiter, thyroid nodule, or thyroid cancer)

Pituitary problem

Adrenal problem

Osteoporosis

Kidney stones

Menstrual problems

If so, what type? _____

Other medical problems (please list)

Current medications and dosages (please list)

Allergies and reactions?

In the **past 6 months** have you experienced any of the following symptoms?

	Yes	No		Yes	No
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>			
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations (heart racing)	<input type="checkbox"/>	<input type="checkbox"/>
Excess hair growth	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath or cough	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/ vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Blurred or double vision	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Joint problems	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction		
Milk discharge from breasts	<input type="checkbox"/>	<input type="checkbox"/>	(loss of interest or erections)	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Do you smoke cigarettes? _____ Packs per day? _____

Number of alcoholic drinks per week _____

Do you have a regular exercise routine? _____ If so, describe _____

If employed, what type of work do you do? _____ Any toxic exposures? _____

FAMILY HISTORY

Does anyone related to you by blood have the following conditions? (Circle)

- | | |
|---|-----------------------|
| Diabetes | Low thyroid levels |
| High blood pressure | High thyroid levels |
| High cholesterol | Adrenal gland problem |
| Heart disease (age <45 for males and <55 for females) | Calcium problem |
| Thyroid cancer | Pituitary problem |
| | Kidney stones |
| | Osteoporosis |

Filled out by _____ Date _____