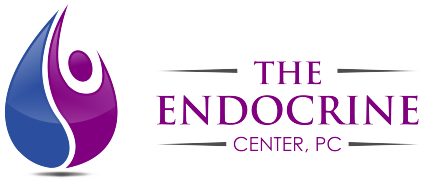

Date

3025 Hamaker Court • Suite 400 • Fairfax VA 22031
Phone (703) 873•7425 Fax (703) 873•7426 Email: info@novaendocenter.com
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New Patient Medical History Form

Print and complete this form prior to your appointment

Date _____

Name _____ **DOB** (mm/dd/yy) _____ **Age** _____

1. Reason for consultation: (what is the main reason for your visit today)

_____

_____

2. Past Medical History: Please select any medical condition from which you have been diagnosed or treated

☐ Cancer
☐ High blood pressure
☐ Diabetes
☐ Thyroid problems
☐ Respiratory problems
☐ Heart Condition
☐ Stomach Ulcers/reflux/ Celiac disease
☐ High Cholesterol/Triglycerides
☐ Kidney problems
☐ Rheumatologic disorders (lupus, rheumatoid arthritis)
☐ Liver problems
☐ Anemia
☐ Stroke
☐ Osteoporosis/Osteopenia
☐ Other, please specify _____

3. Allergies: Please list any allergic reactions or adverse side effects to any drugs, food or environment.

	Type of Reaction
1. _____	_____
2. _____	_____
3. _____	_____

4. Medications: Please list the current prescription and non-prescription medications you are currently taking, specify strength and frequency.

Prescribed: Name	Strength	Times/day	Over the Counter
1. _____	_____	_____	a. _____
2. _____	_____	_____	b. _____
3. _____	_____	_____	c. _____
4. _____	_____	_____	d. _____
5. _____	_____	_____	e. _____

5. Surgical history/hospitalizations: Please select any surgeries or hospitalizations including fractures and traumas you have had in the past.

☐ Tonsils ☐ Appendix ☐ Gallbladder partial/complete
☐ Thyroid • Year _____
☐ Head Trauma • Year _____
☐ Kidney stones • Year _____
☐ Other _____
☐ Heart surgery (CABG/stents)
☐ Parathyroid • Year _____
☐ Hysterectomy: partial/complete
☐ Bone Fracture(s) • Site _____

6. Family History: Please identify all illnesses or medical conditions that are/were present in you blood relatives.

Mother _____ maternal side _____
Father _____ paternal side _____
Brother _____ son/daughter _____
Sister _____

7. Personal/Social History: Tell us about yourself

Home situation
☐ Single ☐ Married/Partner ☐ Divorced/Separated ☐ Widowed

Occupation/Employment _____
☐ Full time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Disabled

Habits
Do you smoke? ☐ Yes ☐ No ☐ Former
If yes, how many packs/day? _____ For how long? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Former
If yes, how many drinks per day/week/month? _____
If you quit, when? _____

Do you use illicit drugs? ☐ Yes ☐ No ☐ Former

How often do you exercise?
☐ Everyday ☐ 1-2 times/wk ☐ 2-3 times /wk ☐ 3-4 times/wk ☐ Seldom/Never

What activity? _____
How long do you exercise for? ☐ 15-20 min ☐ 20-40 min ☐ 40-60 min ☐ 60 – 90 min

Review of Symptoms
Have you experienced any of the following problems recently? ***Check if YES***

General
☐ Weight loss _____ lbs _____ (time period)
☐ Weight gain _____lbs _____(time period)
☐ Poor sleep ☐ Sleep too much
☐ Fatigue/loss of energy
☐ Fever/night sweats/chills
☐ Feeling forgetful
☐ Intolerance to heat or cold

Head, Eyes, Ears, Throat
☐Headaches or migraines
☐ Dizziness/lightheadedness
☐ Blurry or double vision
☐ Dry eyes
☐ History of glaucoma, cataracts
☐ Loss of hearing, ringing in ears
☐ Sinus problems

Neck
☐ Neck swelling/enlargement
☐ Neck pain
☐ Lumps in the neck
☐ Hoarseness, voice changes
☐ Difficulty swallowing

Cardiovascular/Respiratory
☐ Chest pain or discomfort
☐ Palpitation/rapid heart beat
☐ Shortness of breath upon activity
☐ History of heart attack
☐ Irregular heart beat
☐ History of a murmur
☐ Chronic or persistent cough
☐ Wheezing
☐ Coughing up blood

Gastrointestinal
- ☐ Abdominal pain or cramps
- ☐ Constipation
- ☐ Lose stools/diarrhea
- ☐ Blood in the stools
- ☐ Nausea/vomiting
- ☐ History of heartburn (reflux)/ulcer
- ☐ History of liver disease or abnormal tests

Urinary
- ☐ frequent urination day / night
- ☐ History kidney failure
- ☐ History of kidney stones
- ☐ Blood in the urine
- ☐ Excessive thirst
- ☐ Urinary incontinence

Skin
- ☐ Rashes
- ☐ Change in tone or color of skin
- ☐ Excess of hair growth
- ☐ Hair loss
- ☐ Itchiness
- ☐ Bruising easily
- ☐ Purple stretch marks

Muscle/Joint/Bone
- ☐ Muscle aches or pain
- ☐ Muscle weakness
- ☐ Enlargement of hat or finger size
- ☐ History of osteoporosis/ fall
- ☐ History of chronic fatigue

Neurologic/Psychiatric
- ☐ Loss of consciousness/blackout
- ☐ History of stroke
- ☐ Numbness/tingling in hands/feet
- ☐ Leg cramps when walking/at night
- ☐ History of seizures
- ☐ Symptoms of anxiety/depression

Breast
- ☐ Nipple Discharge
- ☐ Masses
- ☐ Tenderness

Hematologic/Lymphatic
- ☐ Swollen lymph node
- ☐ Bleeding/Immune disorder
- ☐ Blood transfusion • Year

Female patients only

- ☐ Age of your first menstrual cycle _____
- ☐ Last date of your cycle _____ ☐ Regular cycles ☐ Irregular cycles
- ☐ Onset of Menopause _____
- ☐ Hysterectomy ☐ Complete (uterus + ovaries) ☐ Partial (uterus)
- ☐ Have you taken estrogen ☐ Yes ☐ No ☐ Duration on treatment _____
- ☐ Are you currently on contraception ☐ Yes ☐ No Specify name and for how long
- ☐ Vaginal discharge
- ☐ Breast discharge or lumps
- ☐ Date of last mammogram _____
- ☐ Date of last pap smear _____
- ☐ Number of pregnancies _____ ☐ Abortions or miscarriages _____
- ☐ Number of Full live births _____

Male patients only

Have you been diagnosed or treated for erection difficulties, prostate problems, prostate surgery, and vasectomy?	☐Y	☐N
Do you have decrease in libido (sex drive)?	☐Y	☐N
Do you have lack of energy?	☐Y	☐N
Do you have a decrease in strength or endurance?	☐Y	☐N
Have you lost height?	☐Y	☐N
Do you feel sad and grumpy?	☐Y	☐N
Are your erections weaker?	☐Y	☐N
Are you falling asleep after dinner?	☐Y	☐N
Has there been a recent deterioration in your work performance?	☐Y	☐N
Have you lost muscle mass?	☐Y	☐N

We appreciate your time in filling out this questionnaire.