



UCLA ENDOCRINE SURGICAL UNIT

INITIAL VISIT HEALTH HISTORY FORM

All information contained in this questionnaire is strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	AGE:
Home address <i>(Street):</i>			Home phone:	
<i>(City/State/Zip):</i>			Mobile phone:	
Email:			Fax:	

Referring MD: Specialty: Address: Cite/State/Zip: Phone: Fax:	Primary/Other MD: Specialty: Address: Cite/State/Zip: Phone: Fax:
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Nearest Relative/Emergency Contact (name): Relation to you: Home phone:	Work phone: Mobile phone:
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MEDICAL HISTORY

Have you ever had any of the following conditions?

DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE
Angina				Stomach ulcer			
Heart attack				Liver disease/cirrhosis			
Heart failure				Kidney disease/dialysis			
Heart murmur				Kidney stones			
High blood pressure				Blood clots/DVT			
Diabetes				Excessive bleeding			
Stroke				Bone loss/osteoporosis			
Asthma				Bone fracture(specify)			
Emphysema				Cancer(specify)			
Pancreatitis				Prior radiation exposure			

List any other medical problems that your doctors have diagnosed

Previous Surgery

Date	Type	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, including vitamins, supplements, and inhalers

Name of Drug	Strength	Frequency Taken

Allergies to medications/foods	Reaction You Had

Social History/Lifestyle							
Occupation				<input type="checkbox"/> If retired, former occupation			
Who lives at home with you?							
What kind of regular exercise do you get?				How many flights of stairs can you climb before becoming tired or short of breath?	<input type="checkbox"/> None	<input type="checkbox"/> One	<input type="checkbox"/> Two
					<input type="checkbox"/> More than two		
(Women) Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		(Women) Are you presently trying to conceive a child?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Smoking	Pks/Day	Yrs smoked	Quit date	Alcohol	#Servings	<input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	

FAMILY HEALTH HISTORY

Do any of the following conditions run in your family?

<input type="checkbox"/> Thyroid disease (specify) _____	<input type="checkbox"/> Other Cancer (specify) _____
<input type="checkbox"/> High calcium	<input type="checkbox"/> Difficulty with anesthesia
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Excessive bleeding
<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> Others (list) _____
<input type="checkbox"/> History of pancreas or brain tumor (circle)	

AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS	
Father				Children	<input type="checkbox"/> M		
					<input type="checkbox"/> F		
Mother					<input type="checkbox"/> M		
					<input type="checkbox"/> F		
Siblings	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			Other/specify	<input type="checkbox"/> M <input type="checkbox"/> F		

REVIEW OF SYSTEMS: PLEASE EXPLAIN ANY YES ANSWERS IN THE SPACE PROVIDED

<u>Constitutional:</u> Fever or chills (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No Weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No Feeling hot <input type="checkbox"/> Yes <input type="checkbox"/> No Feeling cold <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive thirst <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue or low energy level <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of appetite <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Gastrointestinal:</u> Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No Bloody or black stools <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Eyes:</u> Blurred vision <input type="checkbox"/> Yes <input type="checkbox"/> No Double vision <input type="checkbox"/> Yes <input type="checkbox"/> No Dry/irritated eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Genitourinary:</u> Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No Painful urination <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Ear/Nose/Throat/Mouth:</u> Ear infection <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No Change in voice or hoarseness <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Neurological/Psychological:</u> Memory loss or forgetfulness <input type="checkbox"/> Yes <input type="checkbox"/> No Depression or depressed mood <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Respiratory:</u> Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Integumentary:</u> Dry skin <input type="checkbox"/> Yes <input type="checkbox"/> No Itching <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal hair loss <input type="checkbox"/> Yes <input type="checkbox"/> No Abnormal hair growth <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Cardiovascular:</u> Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No Palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Hematologic/Lymphatic:</u> Swollen glands (location) <input type="checkbox"/> Yes <input type="checkbox"/> No Leg swelling one / both (circle) <input type="checkbox"/> Yes <input type="checkbox"/> No Easy bruising <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Musculoskeletal:</u> Bone pain <input type="checkbox"/> Yes <input type="checkbox"/> No Joint pain <input type="checkbox"/> Yes <input type="checkbox"/> No Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No Neck pain <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle pain <input type="checkbox"/> Yes <input type="checkbox"/> No Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Allergic/Immunologic:</u> Seasonal allergies <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Other (list):</u> <input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION: I AUTHORIZE TRANSFER OF MY MEDICAL RECORDS TO THE UCLA ENDOCRINE SURGICAL UNIT AND MY REFERRING PHYSICIANS (LISTED ON FRONT OF PAGE).

Print name:	Signed:	Date:
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