CARROLL HEALTH GROUP

A LifeBridge Health Partner

Carroll Health Group Endocrinology
Patient History Form

Patient name: ______________________________ **Date of birth:** __________

Reason for today's visit: ____

Referring doctor/physician: ____

Medical history: (Please check all that apply)

○Hypertension (high blood pressure)
○Hyperlipidemia (high cholesterol)
○Diabetes
○Diabetic Complications (eyes, kidney, feet)
○CAD (Coronary artery disease)
○Stroke
○Peripheral Vascular Disease
○Irregular heart beat
○Kidney Failure
○Kidney Stones
○Hypercalcemia (high calcium)
○Osteoporosis
○Fractures
○Cancer
○Liver disease
○Anemia
○Sleep Apnea
○Thyroid disease
○Adrenal Disease
○Testosterone (low or high)
○COPD/Asthma
○Depression/Anxiety/other mental illness__________
○Other________________

Surgical History	Date or age at time of procedure

Please list medications below: **(If your list exceeds space provided please bring in a list or continue to back of form)**

Name of Medication	Dosage	Frequency

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Please list allergies below: (If you have no allergies please write none)

Name of medication	Reaction

Social History:

Do you use tobacco in any form? Yes or No

If yes, how much, which form, and how often? ______________________________

Do you drink alcohol beverages? Yes or No

If yes, how much/often? ______________________________

Have you ever used illegal drugs? Yes or No

If yes, which drug and how often? ______________________________

Are you currently using drugs? Yes or No

What is your occupation? ______________________________

Family History	Affected Family Member

Patient signature: ______________________________ **Date:** ____________________