Muncie	2525 University Ave., Suite 300	Muncie, IN 47303	ph 765•281•2000	fx 765•281•2040
Muncie	800 S. Tillotson Ave.	Muncie, IN 47304	ph 765•281•2000	fx 765•281•2044
Cancer Center	2401 University Ave.	Muncie, IN 47303	ph 765•281•2000	fx 765•281•2114
Marion	1399 N. Baldwin	Marion, IN 46952	ph 765•651•2620	fx 765•651•2630
New Castle	2200 Forest Ridge, Suite 120	New Castle, IN 47362	ph 765•593•2960	fx 765•593•2965
New Castle	1000 North 16th, Suite 240A	New Castle, IN 47362	ph 765•521•1461	

Endocrinology History Form

Name: ____DOB: ______________________Date: ________________________
Requesting Practitioner:____Age:______________

Medical History: Please check any of the conditions that represent a SIGNIFICANT problem for you:

General	YES	Cardiovascular	YES	Genitourinary	YES
Fever or chills		Chest pain		Irregular menses (female only)	
Recent weight change		Heart skips beats			
Heat or cold intolerance		Heart beats too fast		Nighttime urination	
Head and Neck	**YES**	Calf pain		Frequent urination	
Choking		Feet, ankle swelling		**Gastrointestinal**	**YES**
Difficulty swallowing		**Lungs**	**YES**	Abdominal pain	
Prolonged hoarseness		Cough		Heartburn/Indigestion	
Change in neck size		Sputum		Constipation	
Skin	**YES**	Wheezing		Frequent diarrhea	
Rash, dryness, itching		Shortness of breath		Nausea or vomiting	
Pigment changes		**Musculoskeletal**	**YES**	**Endocrine**	**YES**
Bleeding tendencies		Bone pain		Excessive thirst	
Eyes	**YES**	Arm/leg weakness		Hot flashes	
Double, failing vision		Leg cramps		Changes in body hair	
Dry eyes		Fractures		Poor sex drive	
Neurologic	**YES**	**Ears, Nose, Mouth**	**YES**	Erection problems	
Light headed/dizziness		Nose bleeds		**Psychiatric**	**YES**
Numbness/tingling		Ear ache		Depression	
Frequent headaches		Ringing in ears		Anxiety	
		Sores in mouth		Other	

If you are a Diabetic, please complete the following questions. (If not, please skip to the back page.)

In what year were you diagnosed with diabetes? _____________
Have you ever been hospitalized for Diabetic Ketoacidosis (DKA)? _____________ How many times? ________________
Do you have a home glucose monitor? _________ How old is the monitor? _______ What brand name?_________________
How often do you check you blood glucose?____
What is the typical glucose reading you obtain before?
Breakfast _______________ Lunch ______________ Dinner ________________ Bedtime ______________
Have you ever experienced symptoms of low blood sugar? ______________ If yes, how often? ________________________
Do you measure your blood glucose level when you get these symptoms? ___________________________________
If yes, at what blood glucose level do you get these symptoms?____
Have you ever been unconscious because of low sugar? ____
Do you have an emergency glucagon (injection) kit? ____
Has diabetes affected your eyes?______ Date of last eye appointment? ___________ Who did you see?________________
To the best of your knowledge, has diabetes affected your kidneys? ____
Do you experience the following, Tingling in your feet/hands? ________________ Diarrhea/vomiting? ________________
Weight loss? _____________________________ Lightheadedness?__________________
If you are on insulin, where do you give injections? Arms ________ Abdomen________ Legs ________ Buttocks ______
Have you ever attended diabetes teaching classes? __________ Where and how long ago?______________________________
Have you ever met with a dietitian? _____________ Where and how long ago?__________________________________
How much has your weight changed over the past year?____
Do you exercise regularly? ______________________ What type of exercise?______________________________
(Females only) If you have been pregnant, were you a diabetic during pregnancy?_________________________________
Do you currently use birth control?____

Please list all of your medications, including over the counter medications. (If you need additional space please bring a list, including dosages, to your appointment)   Include Medication Name, Dosage and Number of Times per Day:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please list allergies

Medication	Reaction

Past Medical History: Please check if you have or had any of the following:

Ulcerative Colitis or Crohn's Disease		TB	
Colon polyps or Colon Cancer		High Blood Pressure	
Liver Disease		High Cholesterol	
Pancreatic Disease		Diabetes	
Osteoporosis		Thyroid Disease	
Bleeding Disorder		Kidney Disease	
Have you ever had a Blood Transfusion		Seizures	
Lung Disease		Psychiatric Disorder	
Heart Disease		Depression	
Other		Other	

Please list any hospitalizations and surgeries, and an approximate date:

Date	Reason for hospitalization or surgery

Family History: List your immediate family members including brothers, sisters and children and their health status:
(Please list on a separate sheet if necessary)

Relative	X if Deceased	Age	Health Problems
Father			
Mother			
Brother/Sister			
Brother/Sister			

Social History:

Marital Status: Single _________ Divorced ________ Married ________ Widow/Widower ________ Other ________

Do you smoke? Yes _______ No _______ If yes, how many packs per day?___________ Number of Years: ______________

Did you smoke? Yes _______ No _______ If yes, when did you quit? __________ Number of Years Smoked: ___________

Do you drink alcohol? Yes _______ No _______ If yes, How often? ______________________________

What do you drink and how much?______________________________

Number of children: __________ Place of employment: ______________________________

Patient Signature: ______________________________ Date:______________________

Physician Signature: ______________________________ Date:______________________