SUMNER STATION FAMILY WELLNESS
HIGHPOINT HEALTH PARTNERS

Dr. Megan McCauley - Endocrinology

PATIENT HISTORY FORM

Past Medical History: Please check if you have had or are currently diagnosed with the following medical conditions.

_____ Diabetes
_____ Adrenal Disease
_____ Pituitary Disease
_____ Cancer
_____ Depression
_____ Anxiety
_____ Other Mental Illness
_____ Heart Disease
_____ Seasonal Allergies
_____Crohn's Disease
_____Ulcerative Colitis
_____ COPD/Lung Disease
_____ High Cholesterol
_____Gout
_____ Rheumatoid Arthritis
_____ Autoimmune Disease
_____ High Blood Pressure
_____ Osteoporosis
_____ Stroke
_____ Asthma
_____ Liver Disease
_____ Glaucoma
_____ Migraines
_____ Seizures
_____ Parkinson's Disease
_____ Alzheimer's
_____ Breast Cancer
_____ Thyroid Disease
_____ Parathyroid Disease
_____ Calcium Problems
_____ Kidney Disease
_____ Pancreas Disease
_____ Cataracts

Any other medical problems not listed above:
____
____

Past Surgical History: Please list all surgeries or Procedures that you have had.

Procedure **Approximate Date**

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____

225 Big Station Camp Blvd., Suite 206

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Family Medical History: Please check if your family members have had any of the following medical conditions.

Disease	Mother	Father	Sibling(s)	Child(ren)	Grandparent(s)
Adrenal Disease					
Pituitary Disease					
Cancer					
Diabetes					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Osteoporosis					
Stroke					
Thyroid Disease					
Parathyroid/Calcium Disease					

Any other medical problems not listed above:
____
____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Occupation: ___________________________ Retired? ________________

Education (highest level attained): _____________________

Tobacco Use: ☐ Never Smoked ☐ Current Smoker ☐ Previous Smoker

☐ Current Chew / Dip

How Many Packs / Day __________ Year Began _______ Year Quit ____________

Are you exposed to secondhand smoke in your home, job, or social life? ☐ Yes ☐ No

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Alcohol Use:

How many glasses of alcohol do you drink per day? _______ per week? _______

Drug Use:

Do you currently use any illegal drugs? __________ If yes, which one(s)? ____________________

Any previous/current IV drug use? _____________ If yes, which one(s)? ____________________

Preventive Care:

Date of last flu vaccination: __________

Date of pneumonia vaccination: __________

Last Eye exam: ____________________ Where: ____________________

Bone Density: _____________________ Where: ____________________

Allergies: ☐ **No Known Drug Allergies**

Name of Medication/Food **Reaction (hives, nausea, etc.)**

1.____

2.____

3.____

4.____

5.____

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Review of Systems: Please check if you have RECENTLY had any of the following:

General: ☐ Chills ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Weight Loss (Amount ________)
☐ Weight Gain (Amount ________)
Cardiovascular: ☐ Chest Pain ☐ Irregular Heartbeat ☐ Swelling of Extremities ☐ Leg Cramps
Neurological: ☐ Burning Sensation ☐ Decreased Memory ☐ Dizziness ☐ Headaches
☐ Numbness / Tingling ☐ Tremor
Gastrointestinal: ☐ Abdominal Pain ☐ Constipation ☐ Diarrhea / Loose Stools ☐ Heartburn
☐ Nausea / Vomiting
Skin: ☐ Dryness ☐ Excessive Sweating ☐ Hair Loss ☐ Itching ☐ Rash
Psychiatric: ☐ Feeling of Depression ☐ Anxious Feeling ☐ Mood Changes ☐ Panic Attacks
Genitourinary: ☐ Blood in Urine ☐ Frequent Urination ☐ Kidney Stones ☐ Painful Urination
Eyes / Ears / Nose / Throat: ☐ Double Vision ☐ Visual Disturbances ☐ Hearing Loss ☐ Hoarseness
Endocrine: ☐ Appetite Changes ☐ Cold Intolerance ☐ Sexual Dysfunction ☐ Excessive Thirst
☐ Excessive Urination ☐ Menstrual Irregularity ☐ Libido Change
Pulmonary: ☐ Cough ☐ Shortness of Breath ☐ Wheezing
Musculoskeletal: ☐ Backache ☐ Joint Pain ☐ Joint Swelling ☐ Muscle Weakness
Hematologic / Lymphatic: ☐ Anemia ☐ Easy Bruising ☐ Enlarged Glands
Breast: ☐ Breast Mass / Swelling ☐ Breast Pain / Tenderness ☐ Nipple Discharge

Medications/Herbs/Vitamins/Supplements: Please list everything that you take daily, as well as those that you take only occasionally or as needed.

Name	Strength	How Often It's Taken	Prescribed By
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

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	Name	Strength	How Often It's Taken	Prescribed By
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Any other medications/herbs/vitamins/supplements not listed above:

Signature Date

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