History Sheet

A. Reza Moattari, MD
Endocrinology,
Diabetes, & Metabolism

Name: _____

YOUR CURRENT CONDITION

1. PLEASE DESCRIBE YOUR MAJOR PROBLEMS OR SYMPTOMS.
   If none, please tell us the reason for this consultation.

2. HAVE YOU SEEN OTHER PHYSICIANS FOR THESE PROBLEMS?
   Please indicate the results of their evaluation and bring any blood test, x-ray, CT scans, etc., results.

Reviewed By: _____ _____
A. Reza Moattari, MD Date

Name: _____

PATIENT MEDICAL QUESTIONNAIRE

MEDICATION STRENGTH AND DOSAGE:

1._____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

NUTRITIONAL SUPPLEMENTS:

1._____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

ALLERGIES TO MEDICATIONS, FOOD, ETC. (PLEASE DESCRIBE THE REACTION/S)

Date	Reason
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

MAJOR ILLNESSES:

Date	Reason
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Reviewed by: _____ _____

A. Reza Moattari, MD Date

Name: _____

PATIENT MEDICAL QUESTIONAIRE

FAMILY HEALTH HISTORY

Please list any significant illnesses in your immediate family. Specifically if any endocrine, diabetes or metabolic disorders (obesity, Bone Disease, gout, kidney stone) in the family. Describe if any autoimmune. (ie. Lupus, Rheumatoid Arthritis, Ulcerative Colitis, Crohn's etc.) in the family.

SOCIAL HISTORY

1. Have you ever smoked? Yes _____ No _____

   When did you quiet? _____

2. Do you drink alcohol? Yes _____ No _____

   What kind? _____ How much? _____ How often? _____

3. Do you use recreational drugs? Yes _____ No _____

   What type? _____ How often? _____

4. Do you exercise? Yes _____ No _____

   What type of exercise do you do? _____

   How often do you exercise each week and for how long is each session? _____

   _____

NUTRITION:

1. How many meals do you eat each day? _____
2. How many times per week do you eat out at restaurants? _____
3. How many sweets do you consume each day? _____
4. How many cups of coffee/black tea/caffeinated soft drinks per day do you drink? _____
5. How many glasses, bottles of water do you drink per day? _____
6. How many cups of milk do you drink per day? _____

Reviewed by: _____ _____

A. Reza Moattari Date

Name: _____

PATIENT MEDICAL QUESTIONAIR

REVIEW OF SYSTEMS (Please check current or recent symptoms/problems from the following list)

GENERAL

_____ Weakness
_____ Fatigue
_____ Weight Change
_____ Night Sweats
_____ Fever
_____ Sensitivity to heat or cold

SKIN

_____ Rashes
_____ Itching
_____ Changes in hair or nails
_____ Changes in color or pigmentation

HEAD

_____ Headache
_____ History of head trauma

EYES

_____ Pain
_____ Double Vision
_____ Blurred Vision
_____ Inflammation or Discharge
_____ Glasses
_____ Surgery
_____ Cataracts
_____ Glaucoma
_____ Retinopathy

EARS

_____ Loss of hearing
_____ Ringing
_____ Pain
_____ Discharge
_____ Bleeding
_____ Postnasal Drip

MOUTH/THROAT

_____ Sores
_____ Bleeding Gums
_____ Hoarseness
_____ Dentures
_____ Change in taste

BREAST

_____ Lumps
_____ Pain
_____ History of Cancer
_____ Nipple Discharge

RESPIRATORY

_____ Chest Pain
_____ Coughing Blood
_____ Wheezing
_____ Phlegm Production
_____ Cough

CARDIOVASCULAR

_____ Trouble breathing when lying down
_____ Waking up suddenly due to cessation of breathing
_____ Shortness of breath at rest or on exertion
_____ Blueness of skin
_____ Leg/Arm swelling
_____ Hypertension
_____ Leg pain when walking
_____ Heart Murmurs
_____ History of Rheumatic Fever

GASTROINTESTINAL

_____ Change in appetite
_____ Difficulty Swallowing
_____ Heartburn
_____ Abdominal Pain
_____ Bleaching
_____ Excess Gas
_____ Abdominal Enlargement
_____ Vomiting
_____ Rectal Bleeding
_____ Black Stools
_____ Constipation
_____ Jaundice
_____ Nausea
_____ Diarrhea
_____ Hemorrhoids
_____ Need for Laxatives
_____ History of Hepatitis B or C
_____ Vomiting Blood

BLOOD/LYMPHATIC

_____ Anemia
_____ Transfusions
_____ Bleeding Tendency
_____ Clotting Problems
_____ Lymph Node Enlargement/Pain

Reviewed by: _____ _____

A. Reza Moattari, MD Date

Name: _____

PATIENT MEDICAL QUESTIONAIR

GENITOURINARY

_____ Urinary frequency or urgency
_____ Nighttime need to urinate
_____ Blood in urine
_____ Incontinence
_____ Impotence
_____ Loss of Libido
_____ Pain with Intercourse
_____ Testicular Pain or Swelling
_____ Gonorrhea, Syphilis
_____ Contraception
_____ Genital Herpes
_____ Recurrent Urinary Tract Infection

ENDOCRINE

_____ Goiter
_____ Hypothyroidism
_____ Head Trauma
_____ Kidney Disease
_____ Hirsutism
_____ Sexual Dysfunction
_____ Milky Breast Discharge
_____ Diabetes
_____ Hyperthyroidism
_____ Thyroid Nodule
_____ Hypoglycemia
_____ Hypertension
_____ Low Sex Drive
_____ Infertility
_____ Prednisone Treatment
_____ Pituitary Disease
_____ Calcium Problems
_____ Adrenal Disorder
_____ Gout
_____ Irregular Periods
_____ Polyuria (urinating too much)

JOINTS/MUSCLE

_____ Muscle Cramps
_____ Muscle Weakness
_____ Joints Pain
_____ Swollen Joints
_____ Deformity of Joints

NEUROLOGIC

_____ Fainting
_____ Abnormal Gait
_____ Seizures
_____ Speech Impairment
_____ Loss of sensation
_____ Paralysis
_____ Memory Loss
_____ Depression
_____ Dizziness

GYNECOLOGIC HISTORY

_____ Pregnancies # _____
_____ Deliveries # _____
_____ Miscarriage # _____
_____ Abortions # _____
_____ Fibroids
_____Hysterectomy
_____ PMS
_____ Irregular Periods
_____ Painful Periods
_____ Hormone Replacement Therapy
_____ Abnormal Mammogram Test
_____ Abnormal PAP Smear Test
_____ Abnormal Bone Density Test
_____ Date Last Period Began _____

SCREENING TESTS:

Procedure	**Date**	**Results**
Colonoscopy		
Sigmoidoscopy		
CXR		
PAP Smear Test		
Mammogram Test		
Bone Density		
Stress Test		
EKG		
All body CT- Scan		
Angiography		
Other		

Reviewed by: _____ _____
A. Reza Moattari Date