BOULDER ENDOCRINOLOGY ASSOCIATES
NEW PATIENT HISTORY FORM

NAME_____
DOB_____/_____/_____

DO YOU HAVE (OR HAVE YOU HAD) ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO
DIABETES			ASTHMA		
HIGH BLOOD PRESSURE			EMPHYSEMA OR COPD		
HIGH CHOLESTEROL			ANEMIA		
HEART PROBLEMS			STOMACH ULCER		
STROKE			HEARTBURN		
SEIZURES			ARTHRITIS		
THYROID PROBLEMS			HIV INFECTION		
LIVER PROBLEMS			ANXIETY		
KIDNEY PROBLEMS			PANIC ATTACKS		
CANCER			DEPRESSION		

PLEASE LIST ANY OTHER MEDICAL PROBLEMS YOU HAVE OR ANY OTHER REASON YOU SEE A DOCTOR:

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD, WHERE THESE OCCURRED, AND THE YEAR PERFORMED:

DATES OF IMMUNIZATIONS:
PNEUMONIA _____ FLU_____ POLIO _____ TETANUS_____
DIPHTHERIA _____ OTHER_____

PLEASE LIST ANY MEDICATION **ALLERGIES** OR BAD **REACTIONS** TO MEDICATIONS THAT YOU HAVE HAD:

WHAT IS YOUR MARITAL STATUS? _____
HOW MANY CHILDREN DO YOU HAVE? _____
WHAT IS YOUR OCCUPATION? _____

DO YOU SMOKE? ☐YES ☐ FORMER ☐ NEVER
DRINK ALCOHOL? ☐YES ☐NO

FAMILY HISTORY:

	AGE IF LIVING	AGE AT DEATH	CAUSE?
MOTHER			
FATHER			
BROTHERS			
NO. LIVING			
NO. DEAD			
SISTERS			
NO. LIVING			
NO. DEAD			

HAVE ANY FAMILY MEMBERS BEEN DIAGNOSED WITH THE FOLLOWING? WHO HAS THIS?

DIABETES	☐ YES ☐ NO	
HIGH BLOOD PRESSURE	☐ YES ☐ NO	
HIGH CHOLESTEROL	☐ YES ☐ NO	
HEART ATTACKS AND/OR BYPASS SURGERY	☐ YES ☐ NO	
STROKE	☐ YES ☐ NO	
CANCER	☐ YES ☐ NO	
THYROID PROBLEMS	☐ YES ☐ NO	
KIDNEY STONES	☐ YES ☐ NO	
OSTEOPOROSIS	☐ YES ☐ NO	

FOR WOMEN ONLY:
HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST MENSTRUAL CYCLE? _____
ARE YOUR MENSTRUAL CYCLES REGULAR? ☐ YES ☐ NO
WHAT WAS THE DATE YOUR LAST MENSTRUAL CYCLE STARTED? _____
HAVE YOU GONE THROUGH MENOPAUSE?
☐ NO ☐ YES, AT AGE _____
HOW MANY TIMES HAVE YOU BEEN PREGNANT? _____
HOW MANY CHILDREN HAVE YOU HAD? _____
HOW MANY MISCARRIAGES HAVE YOU HAD? _____

PLEASE LIST ALL YOUR MEDICATIONS IN THE TABLE BELOW.

MEDICATION NAME	**PILL SIZE** *(HOW MANY MILLIGRAMS?)*	**TIMES TAKEN AND NUMBER OF PILLS TAKEN** *(EXAMPLE – TWO AT BREAKFAST, ONE AT DINNER)*

(PLEASE INCLUDE HORMONE MEDICATIONS, BIRTH CONTROL PILLS, HERBAL MEDICINES, VITAMINS, DIET SUPPLEMENTS, OR OVER-THE-COUNTER MEDICINES THAT YOU TAKE ON A REGULAR BASIS. IF YOU NEED MORE SPACE, PLEASE USE THE BACK OF THIS FORM.)