Endocrinology Associates of Central NJ

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WELCOME TO OUR OFFICE!
Please fill in forms to help with your visit.

Name:_____

Date:_____

Problem you are here for:_____
_____

Medical History: (Please Circle)

High blood pressure..... .No Yes
Diabetes.....No Yes
Heart Disease..... No Yes
Cancer.....No Yes
Arthritis.....No Yes
Stomach Ulcer..... No Yes
Eye Disease..... No Yes

Thyroid. (overactive, underactive, goiter).....No Yes
Kidney stones..... No Yes
Acute Infections..... No Yes
Venereal Disease..... No Yes
Hereditary defects.....No Yes
Bleeding tendency.....No Yes

Previous Hospitalizations/Surguries/

_____
_____
_____
_____
_____

Other Medical Problems:(Please list)

_____
_____
_____

Medications: (Name & Dose)

_____
_____
_____
_____
_____
_____
_____

Allergy to Meds:_____

Social History:

Marital status: Single___Married___Separated___Divorced___Widowed___
Use of alcohol: Never___ Rarely____ Moderate___ Daily____
Use of tobacco: Never___ Previously, but quit____ Current packs/day_____
Use of drugs: Never___ Type/Frequency_____ Occupation:_____

Family History:

	Age	Diseases
Father	____	_____
Mother	____	_____
Siblings	____	_____
	____	_____
Spouse	____	_____
Children	____	_____
	____	_____

Family history of: (please circle)
(state who)

Diabetes

Hypothyroidism Goiter

Hyperthyroidism

Reviewed by:_____ Date_____
All other systems negative