Thyroid & Endocrine Center of South Texas
540 Madison Oak Dr., Suite 270
San Antonio, TX 78258
Phone 210 491-9494, fax 210 491-9696

INTAKE HISTORY: Please, do not leave any questions unanswered.

Name_____ **date of birth**_____ **Age**_____ **Date:**_____

How did you hear about Dr. Hands: physician referral / TV / magazine / WEB / Friend / other

What doctor sent you here: Dr. _____ /Self referral: Y / N
Who is your primary care physician: Dr. _____ (letter will be sent unless you otherwise specify)
Doctor address _____
Doctor Phone: _____ FAX#_____

WHAT CONDITION WERE YOU REFERRED FOR: _____
How long have you had this medical condition? _____
How was it diagnosed and treated till now:
_____
_____

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE FOLLOWING:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Headaches			Heat intolerance			Chest pain		
Tired/fatigue			Excessive Dry skin			Short of breath		
Low energy			Excessive hair loss			Feet swelling		
Daytime drowsiness			Urinating excessively			Heart racing for no apparent reason		
Abnormal Weight gain			Drinking excessively			Irregular heart beat		
Abnormal Weight loss			Numbness/tingling toes			Abnormal liver tests		
Nervous for no reason			Muscle cramps daily			Abnormal gas and bloating		
Choking on solids			Nausea or vomiting past 24 hr			Kidney stones		
Choking on liquids			Chronic constipation			Fibroid tumors		
difficulty swallowing			Frequent diarrhea			joint pain/swelling		
Voice change/hoarse			Visual changes (not age relat.)			Chronic Rash		
Painful swallowing			Breast discharge			vitiligo		
Neck Pressure			Excessive bruising			Obesity		
Radiation to head/neck			Long term steroid use			OTHER COMPLAINTS:		
Family history thyroid cancer?			Purple stretch marks					

EXPLAIN ANY YES ANSWERS:
_____
_____
_____
_____

WOMEN only:

age of FIRST period:	CURRENT birth control method:
LAST period DATE:	Year of Last GYN exam
How many pregnancies:#	Last Mammogram (year):
How many live births:#	**Menopause age:**
Fibroid tumors: Y / N	Current use estrogen? **Y / N**
Heavy menstrual bleeding: Y / N	Have you used meds for GERD? **Y / N**
Are you planning pregnancy within next 12 months? **Y /N**	Bone density study PERFORMED **Y / N** , year:
Less the 4 periods/year **Y / N**	**BMD results: normal or osteopenia or osteoporosis**
Have you been treated for infertility **Y / N**	**Have you ever been treated with osteoporosis med. Y / N**

HAVE *YOU* EVER BEEN TREATED OR DIAGNOSED WITH: (PAST MEDICAL HISTORY)

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Stroke			Hyperthyroidism			Diabetes		
High blood pressure			Hypothyroidism			Diabetic kidney disease (nephrop)		
High cholesterol			Thyroid nodule			Diabetic eye disease (retinopathy)		
CHF (cong. Heart fail.)			Goiter (enlarged thyroid)			Diabetic nerve damage (neurop,)		
Heart attack			Adrenal disorder			Frequent Bladder/kidney infections		
Stent placement			Low testosterone (men)			Kidney stones		
Angina			PCOS (polycystic ovary)			Vitamin D deficiency		
Arrhythmia/irregular beat			Pituitary disorder			B12 deficiency		
Emphysema/COPD			Breast discharge			Celiac sprue		
Asthma			obesity			vitiligo		
Sleep apnea			Liver disease			anemia		
Migraines			Abdominal pain/bloating			**Others:**		
Past/current Drug abuse			GERD					
Past/ current alcoholism			Peptic ulcer disease					
Current Tobacco use			Fracture bone without trauma					
Depression/anxiety			Osteopenia (low bone mass)					
Cancer (what kind)			Osteoporosis					
			menopause					

Explain when condition started and treatment for each yes response:

_____

_____

_____

ALLERGIES TO MEDICATIONS: LIST DRUG AND THE REACTION YOU SUFFERED

DRUG:	**Type of REACTION**

LIST ALL MEDICATIONS, OVER THE COUNTER PREPARATIONS AND VITAMINS/HERBS

MEDICATIONS:	**DOSE**	**TIME TAKEN (ie 7:15am)**	**PRESCRIBED FOR WHAT CONDITION**

Please BRING all medications, including over-the-counter medications/vitamins TO YOUR VISIT

List other over the counter meds used: _____

FAMILY HISTORY: **STATE: *GOOD HEALTH OR MEDICAL CONDITION DIAGNOSED OR TREATED FOR:***

Father: alive / deceased, age: _____condition:, _____

Mother: alive / deceased , age _____Condition:, _____

Brothers: alive / deceased , ages____ Condition:_____

Sisters: alive / deceased, ages____ Condition:_____

Children alive / deceased, ages_____ Condition:_____

SOCIAL HISTORY: ANSWER ALL QUESTIONS

Have you ever smoked: Yes / No	Are you employed: Yes / No
When did you quit _____	What is your trade/profession:_____
How much did (do) you smoke: pack/day:_____	Who do you live with:_____
How many Beer /Wine / Liquor: drinks/week _____	Do you do FORMAL exercise Yes / No
Do you do any illicit drugs? Yes / No	How many times/week: ____ how long/ session: ____

SURGERY: List all surgeries: reason and year: if none, write "NONE"

_____

_____

_____

_____

HEALTH MAINTINENCE: LIST YEAR OF EXAM:

Last Eye exam:	Last Tetanus booster:
Last Dental exam:	Last Mammogram/Prostate exam:
Last Flu vaccine:	Last Colonoscopy:
Last Pneumococcal vaccine:	Heart evaluation: Stress test/ ECHO/ Cath:

MEALS: TYPICAL TIMES ON AVERAGE

Time you awake: _____
Breakfast time: _____
Lunch: _____
Supper time: _____
Bed time: _____

TYPICAL FLUIDS YOU DRINK:

_____
_____
_____
_____
_____

CONTACT INFORMATION:

Please list your phone number(s) where our office can contact you in regards to this form and making appointments:

_____
_____
_____
_____