DENVER
Endocrinology, Diabetes & Thyroid CENTER, PC
799 E Hampden Ave, Suite 525, Englewood, CO 80113
Phone: 303-321-2644 Fax: 303-321-2446 Website: www.denverendocenter.com

Patient Name_____ Today's Date_____
Date of Birth_____ Occupation_____
Primary Care Provider_____ Phone_____
Referring Physician(if not PCP)_____ Phone_____
Other Care Providers_____ Phone_____
Main Concern(s)/Reason for visit today_____
ALLERGIES (Please include type of reaction to each allergy listed)_____

MEDICATIONS (Both prescription and over-the-counter including herbal,vitamins,etc)
Please include another page if needed.
Name of medication and dosage

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

HOSPITALIZATIONS/SURGERIES/PROCEDURES (Please include exact date or at least year)

_____ _____
_____ _____

FAMILY HISTORY (List any health problems of your mother, father, siblings, children or grandparents only)

_____
_____
_____
_____
_____

SOCIAL HISTORY (Circle all that apply)

Current smoker yes/no number of cigarettes per day
Previous smoker yes/no date quit:_____
Alcohol use yes/no number of drinks per day
Exercise yes/ no number of days in a week
duration/type of exercise_____

PERSONAL HISTORY (Previous health problems)

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

REVIEW OF SYSTEM (Circle current problems/symptoms you are experiencing now in past 1 month)

❑Weight gain
❑Weight loss
❑Fatigue
❑Easy bruising
❑Excessive sweating
❑Brittle nails
❑Rash
❑Change in skin color
❑Dry skin
❑Stretch marks
❑Darkening of skin
❑Peripheral vision loss
❑Worsening vision
❑Blurred vision
❑Bulging eyes
❑Headache
❑Double vision
❑Hoarseness
❑Snoring
❑Inability to smell
❑Change in dental bite
❑Change in head size
❑Neck pain (front)
❑Swollen glands
❑Neck lump
❑Neck swelling

❑Difficulty breathing
❑Breast Pain
❑Breast Discharge
❑Breast Enlargement
❑Chest pain/discomfort
❑Leg pain with exercise
❑Palpitations
❑Abdominal pain
❑Constipation
❑Diarrhea
❑Diarrhea with milk
❑Difficulty swallowing
❑Nausea
❑Vomiting
❑Pain with swallowing
❑Impotence
❑Abnormal periods
❑Pain with intercourse
❑Pain with urination
❑Kidney stones
❑Bone pain
❑Back pain
❑Joint pain
❑Muscle cramps
❑Muscle weakness
❑Pain in hands

❑Pain in feet
❑Fractures
❑Muscle aches
❑Change in hand size
❑Change in foot size
❑Dizziness
❑Fainting
❑Weakness
❑Lightheadedness
❑Dizziness with standing
❑Change in concentration
❑Change in memory
❑Frequent falls
❑Emotional swings
❑Numbness in hands/feet
❑Burning in hands/feet
❑Anxiety
❑Depression
❑Difficulty sleeping
❑Acne
❑Decrease in appetite
❑Increase in appetite
❑Feeling full before done eating
❑Cold intolerance
❑Excessive thirst

❑Excessive urination
❑Heat intolerance
❑Hot flashes
❑Flushing
❑Excess face/body hair
❑Loss of hair
❑Decrease in height
❑Decrease in sex drive
❑Other_____

Height:_____

Weight:_____

Local Pharmacy:
_____

Mail Order Pharmacy:
_____

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