ENDOCRINOLOGY ASSOCIATES

Board Certified Physicians
American Board of Internal Medicine
Eric A Orzeck MD FACP FACE

Samir G Ouais MD*

Certified / Licensed Associates
Faith Sanders PA-C

Patient Name: _____ Date of Birth: _____

Patient Past Medical History:

Have you had any of the following?

Heart Disease	Yes	No	Anemia	Yes	No	Hemorrhoids	Yes	No
High/ Low Blood Pressure	Yes	No	Arthritis	Yes	No	Hepatits___	Yes	No
Stroke	Yes	No	Asthma	Yes	No	Hives/Eczema	Yes	No
Mitral Valve Prolapse	Yes	No	Back Trouble	Yes	No	Migraine Headaches		
Thyroid Problems	Yes	No	Bladder Infections	Yes	No	Pneumonia	Yes	No
Diabetes	Yes	No	Bleeding Disorders	Yes	No	Tuberculosis	Yes	No
Kideny Disease	Yes	No	Blood Transufion	Yes	No	Ulcer	Yes	No
Glaucoma	Yes	No	Bronchitis	Yes	No	Venereal Diseas/ STI	Yes	No
Cancer _____	Yes	No	Epilepsy	Yes	No	Other _____	Yes	No
HIV/ AIDS	Yes	No	Hernia	Yes	No	Other _____	Yes	No

Family History:

Relative:	Living?		Present Age / Age at Death	Current Medical Issues/ Cause of Death
Father	Yes	No	_____	_____
Mother	Yes	No	_____	_____
Siblings (list below if sister or brother)				
_____	Yes	No	_____	_____
_____	Yes	No	_____	_____
Children	Yes	No	_____	_____
Maternal Grandmother	Yes	No	_____	_____
Maternal Grandfather	Yes	No	_____	_____
Paternal Grandmother	Yes	No	_____	_____
Paternal Grandfather	Yes	No	_____	_____

Social History:

Have you ever smoked?	Yes	No
Do you drink Alcohol?	Yes	No
Do you use caffeine?	Yes	No
Illicit Drug Use?	Yes	No
Are you married?	Yes	No

Description: _____
Do you have children? _____
Occupation: _____

Surgeries:	Year:	Immunizations:	Date:	Allergies:
_____	_____	Flu	_____	_____
_____	_____	Pnuemonia	_____	_____
_____	_____	_____	_____	_____