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HERITAGE VALLEY
HEALTH SYSTEM

Heritage Valley Medical Group-Endocrinology
Samantha DeMauro-Jablonski, MD
Lucas Heller, MD
Hira Ali, MD
Karen Mayo, CRNP
Jenna Federoff, CRNP

Name:	**Appointment Date:**
Date of Birth:	**Home Phone:**
Cell Phone:	**Work Phone:**
Primary Care Physician:	**Office Location of PCP:**
Referring Physician (if different):	**Office Location of Referring:**
Email:	

REASON FOR TODAY'S VISIT:____

____

PAST MEDICAL HISTORY:

CARDIAC	**RESPIRATORY**	**GENITOURINARY / REPRODUCTIVE**
☐ High Blood pressure	☐ Asthma	☐ Many urine infections
☐ Heart attack	☐ Chronic Cough	☐ Kidney stones
☐ Heart murmur	☐ Bronchitis	☐ Infertility
☐ Irregular heartbeat	☐ Emphysema	Males:
☐ Stroke		☐ Erectile Dysfunction
☐ Mitral valve prolapse	**GASTROINTESTINAL**	
☐ Peripheral Vascular Disease	☐ Ulcers	Females:
☐ Congestive Heart Failure	☐ Irritable Bowel	☐ Gestational Diabetes
	☐ Constipation	☐ Irregular periods
MUSCULOSKELETAL	☐ Diverticulitis	Date of last period:__________
☐ Arthritis	☐ Crohns / colitis	Age of Menopause: _________
☐ Spine or Hip Fracture		
☐ Other ____________________	**HEMATOLOGIC**	**CANCER**
	☐ Easy bleeding / bruising	☐ Type: ____________________
NEUROLOGIC	☐ History of blood clot	
☐ Spine / back injury		
☐ Seizures	**ENDOCRINE**	
☐ Migraines	☐ Diabetes	Females:
☐ Recurrent headaches	☐ Thyroid	☐ Polycystic Ovarian Syndrome
	☐ Osteoporosis	☐ Unwanted facial or body hair
	☐ High cholesterol	Other: ___________________
	☐ Steroid use	_________________________
	☐ Excessive weight gain	_________________________

PAST SURGICAL HISTORY: (Please list your surgeries and approximate dates)

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LIFESTYLE AND SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Who do you live with: ______________________ Number in Household? ________

Current Occupation: ______________________ Exercise (Type & Frequency): ______________________
Diet: ______________________

Do you currently use tobacco products: ☐ YES ☐ NO If so, type: __________ How much?: __________
For how long?: ______________________
Would you like assistance with tobacco cessation? ☐ YES ☐ NO

If not currently using tobacco, did you use tobacco in the past? ☐ YES ☐ NO If so, type: __________
How much?: __________ For how long?: ______________________

Alcohol Intake: Drinks per day / week: ______________________

Do you use recreational drugs? ☐ YES ☐ NO If no, have you ever? ☐ YES ☐ NO If so, what and how often? __________

REVIEW OF SYSTEMS: Please check if you are currently experiencing any of the following:

GENERAL WELL-BEING	CARDIOVASCULAR	EARS, NOSE, THROAT, MOUTH
☐ Weight loss	☐ Shortness of Breath	☐ Ulcers
☐ Weight gain	☐ Chest Pain	☐ Sinus Problems
☐ Fever	☐ Palpitations	☐ Hearing Problems
☐ Fatigue	☐ Swelling	☐ Ringing in the Ears
☐ Excessive Thirst	RESPIRATORY	☐ Difficulty Swallowing
☐ Excessive Hunger	☐ Coughing	☐ Hoarseness
☐ Problems Sleeping	☐ Coughing up Blood	BREAST
☐ Heat Intolerance	☐ Wheezing	☐ Pain
☐ Cold Intolerance	EYES	☐ Nipple Discharge
BLOOD SYSTEM	☐ Vision Changes	☐ Breast Lump
☐ Bleed Easily	☐ Contacts / Glasses	MUSCULOSKELETAL
☐ Bruise Easily	☐ Double Vision	☐ Weakness
GASTROINTESTINAL	☐ Dry Eye	☐ Muscle Pain
☐ Diarrhea	NEUROLOGICAL	☐ Joint Swelling
☐ Constipation	☐ Dizziness	URINARY / GYNECOLOGIC
☐ Nausea / Vomiting	☐ Migraine headaches	☐ Blood in Urine
☐ Bloody Stools	☐ Numbness	☐ Painful Urination
☐ Abdominal Pain	☐ Difficulty walking	Women: ☐ Irregular Periods
PSYCHOLOGICAL	☐ Tremors	SKIN
☐ Depression	SLEEP DISTURBANCE	☐ Acne
☐ Severe Mood Swings	☐ Difficulty Falling Asleep	☐ Hair Loss
☐ Anxiety	☐ Waking up frequently at night	☐ Excessive Hair Growth
☐ Confusion	☐ Excessive sleepiness during day	☐ Dryness
☐ Severe Agitation	☐ Sleep apnea	☐ Rash

(see page 3)

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Name:	**Date of Birth:**

PERIODIC HEALTH SCREENING: *When was your last:*

Flu Vaccine:	Pneumonia Vaccine:	Dental Exam:
Dilated Eye Exam:	Last Foot Exam:	Podiatrist Name:
Bone Densitometry:	Ophthalmologist Name:	

FAMILY HISTORY – Have any of your family members ever had any of the following? Please cross out any family listed below that does not apply to you……(Example: if you don't have a sister, just cross out sister)

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Arthritis – Rheum								
Arthritis – Osteoporosis								
Asthma								
Cancer								
Diabetes								
Heart Failure								
High Cholesterol								
Hypertension								
Migraines								
Rashes / Skin Problems								
Seizures								
Stroke								
Thyroid Disease								

Are there any concerns that you would like to discuss at today's visit?____