Village Health Partners
Aparna Ayyagari, MD

Patient Medical History
Endocrinology

Name: _____ **Date:** _____

Patient's reason for office visit: _____

Please circle any illness or condition you have had:

Adrenal disorder
Abnormal Pap smear
Alcoholism
Allergies
Anemia
Anxiety
Arthritis
Asthma
Back pain, chronic
Breast Cancer
Colon polyp
COPD
Depression (current)
Depression (past)
Diabetes Type I
Diabetes Type II
Diabetes, gestational
Diverticular disease
Eczema
Endometriosis
Erectile dysfunction
Fibromyalgia
Genital herpes
Heart disease
Hirsutism
Glaucoma
Hemorrhoids
High cholesterol
High blood pressure
Irritable bowel
Kidney stones
Low thyroid
Migraine
Obesity
Osteoporosis
Osteopenia
Parathyroid disorder
Polycystic ovarian syndrome
Postmenopausal
Prostate enlargement
Pituitary disorder
Reflux
Rheumatoid arthritis
Seizure disorder
Sleep Apnea
Stroke
Tobacco use
Thyroid disease
Thyroid cancer

SURGERIES
Appendix
Ear tubes
Gall bladder
Heart bypass
Hernia repair
Knee ACL
Knee other
Lumbar back
Neck C-spine
Shoulder
Tonsils

Women
Breast augmentation
C-section
Hysterectomy
Tubal ligation

Other: _____

Family History (please include any medical illnesses and cause of death)

Father:_____
Mother:_____
Siblings:_____
Other:_____

Social History (please circle Yes or No)

Occupation: _____
Tobacco Use: YES/NO Type:_____
Alcohol Use: YES/NO How often:_____
Exercise: YES/NO How often: _____

Routine Health Screening (most recent dates)

Colonoscopy:_____
Mammogram:_____
Pap Smear:_____
Bone Density:_____
Tetanus Booster:_____

Past Surgical History:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Medications (Please include "over the counter meds" as well) Please list all diabetic medications on Diabetes Form.

Name	Strength	How Often

Drug Allergies (include reaction):_____

Non-Drug Allergies (include reaction):_____

Pharmacy Name & Location:_____ Phone:_____ Fax:_____