

CURTIS TAKEMOTO-GENTILE, MD

MEDICAL HISTORY FORM

Patient Name: _____

CURRENT MEDICATIONS

| | Name of Medication(s) & Supplement(s) currently being taken | Dosage | Frequency |
|----|---|--------|-----------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

MEDICAL HISTORY

| | | | | |
|-----------------------------------|-----|-----------|--------|-------|
| Immunizations (enter date) | Flu | Pneumovax | Tetnus | Other |
|-----------------------------------|-----|-----------|--------|-------|

History of Cancer: (current or past)

| | Type | Date |
|----|------|------|
| 1. | | |
| 2. | | |

Female Patients:

| | |
|-------------------------|------------------------------------|
| Date of Last PAP: | First Day of Last Menstrual Cycle: |
| Date of Last Mammogram: | Date of Last Thermogram: |

ALLERGIES/DRUG ALLERGIES/INTOLERANCE:

| | Please List ALL Drug, Food and Other Allergens | Type of Reaction |
|----|--|------------------|
| 1. | | |
| 2. | | |
| 3. | | |

SURGICAL HISTORY/HOSPITALIZATIONS

| | Date (month/year) | Surgery/Reason for Hospitalization |
|----|-------------------|------------------------------------|
| 1. | | |
| 2. | | |
| 3. | | |

FAMILY HISTORY

| | Living or Deceased** | DOB | Current Age | Health History (i.e. diabetes, heart disease, any other health concerns) **if deceased, at what age and cause of death** |
|----------------------|----------------------|-----|-------------|---|
| Father | | | | |
| Sisters | | | | |
| Mother | | | | |
| Paternal Grandfather | | | | |
| Paternal Grandmother | | | | |
| Maternal Grandfather | | | | |
| Maternal Grandmother | | | | |
| Brothers | | | | |

| | | | | | | | |
|--------------|--|---------------|--|----------------|--|-----------|--|
| # of Sisters | | # of Brothers | | # of Daughters | | # of Sons | |
|--------------|--|---------------|--|----------------|--|-----------|--|

| SOCIAL HISTORY | | | | |
|----------------|-------------|-----|-----------|--------------|
| | | Y/N | Frequency | Details/Type |
| 1. | Smoking | | | |
| 2. | Alcohol Use | | | |
| 3. | Drug Use | | | |
| 4. | Exercise | | | |
| 5. | Caffeine | | | |

Hypothyroidism Symptom Checklist

Please place a check next to any symptom/procedure that applies to you.

- | | | |
|---|--|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Fatigue/Tiredness/Weakness |
| <input type="checkbox"/> Cold Feet/Hand | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Feeling Cold, Dressing Warmly |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Brittle Nails | <input type="checkbox"/> Soft/Ridged Nails | <input type="checkbox"/> Curved/Ingrown Big Toenails |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Swelling of Hands/Fingers | <input type="checkbox"/> Swollen Upper Eyelids |
| <input type="checkbox"/> Hair Loss-Head | <input type="checkbox"/> Hair Loss at Armpits | <input type="checkbox"/> Hair Loss-Outside Edge of Eyebrows |
| <input type="checkbox"/> Hair Loss-Forearm | <input type="checkbox"/> Tingling/numbness | <input type="checkbox"/> TMJ-Teeth Clenching |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Infertility | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety/Tension | <input type="checkbox"/> Lack of Perspiration |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Allergies | <input type="checkbox"/> Irregular Heart Rate |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Ear Ringing (Tinnitus) | <input type="checkbox"/> Ovarian Cyst | <input type="checkbox"/> Frequent Colds and Infections |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Deep Hoarse Voice | <input type="checkbox"/> Fibrocystic Breast |
| <input type="checkbox"/> Skin Moles | <input type="checkbox"/> Skin Cancers | <input type="checkbox"/> Brain Fog/Slow Memory |

Who in your Family has Hypothyroidism? _____

Is your Body Temperature less than 98°F? YES or NO

What is your Average Body Temperature? _____