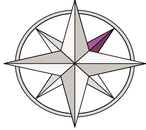

Dr. Laura S. Akright
5000 Schertz Parkway #200 • Schertz, Texas 78154
210.650.3360 (office) • 210.650-5384 (fax)
www.neendocrinology.com

General Patient Information

Welcome to our practice! Please take a moment to fill out the following health questions:

Patient Name: ______________________________ Today's Date: ____ / ____ / ____

Preferred Name: ______________________________

Prior medical problems - *check all those that apply:*

- ☐ **Migraine** ☐ **Asthma** ☐ **Kidney stones** ☐ **Stomach ulcers**
- ☐ **Liver problems** ☐ **High blood pressure** ☐ **High cholesterol** ☐ **Diabetes**
- ☐ **Thyroid disease** ☐ **Osteoporosis** ☐ **Depression** ☐ **Other:** ______________

Prior surgeries - *circle all those that apply, give dates if possible*:

- ☐ **Hysterectomy** ____ / ____ / ____ ☐ **Tonsillectomy** ____ / ____ / ____
- ☐ **Appendix removal** ____ / ____ / ____ ☐ **Gallbladder removal** ____ / ____ / ____
- ☐ **Prostate surgery** ____ / ____ / ____ ☐ **Breast surgery (cancer?** ☐ **benign?** ☐ **)** ____ / ____ / ____
- ☐ **Other:** ______________ ____ / ____ / ____

Primary Care Physician (PCP): ______________________________

Referring physician *if different from above*: ______________________________

Do you drink milk or dairy products? ☐ Yes ☐ No If yes, how many servings per day? __________

Do you use caffeine (coffee, tea, soda)? ☐ Yes ☐ No If yes, how many servings per day? __________

Do you drink alcoholic beverages such as wine, beer, or mixed drinks? ☐ Yes ☐ No
If yes, how many servings per day? __________

If you have ever used tobacco:

Tobacco Use: ☐ **Current** ☐ **Former** ☐ **Never** Type: ☐ **cigarettes/cigars** ☐ **chewing tobacco** ☐ **snuff**

How much a day? ______________ Year quit: ________

Years used: ____ Release reason: ______________

Ever tried to quit? ☐ **Yes** ☐ **No**

Do you have a ***family history*** *of - check all that apply and list family member next to disease.*

- ☐ **Diabetes** __________ ☐ **Thyroid Disorders** __________ ☐ **Colon Cancer** __________
- ☐ **High Cholesterol** __________ ☐ **High Blood Pressure** __________ ☐ **Obesity (overweight)** __________
- ☐ **Skin Disease** __________ ☐ **Migraines** __________ ☐ **Depression** __________
- ☐ **Breast Cancer** __________ ☐ **Infertility** __________ ☐ **Arthritis** __________
- ☐ **Coronary Heart Disease (Heart Attack or Surgery)** __________ ☐ **Osteoporosis/Hip Fractures** __________
- ☐ **Other:** ______________