ACCESS ENDOCRINE CENTER, PC
MODHI GUDE, M.D., MRCP(UK), FACP,
6001 NW 120th Court, Suite 6, OKC, OK 73162 (405) 728-7329 –or-
1552 SW 44TH Street, OKC, OK 73109 (405) 681-1100

PATIENT INFORMATION FORM (MEN ONLY)

Name: ______________________________ Age: ________ Sex: ________ Birthdate: _____/ _____/ _____

SS # ________________________________

A. Describe briefly your present symptom(s) or the reason(s) for seeing the doctor today:

____
____
____

B. Name all illnesses or conditions for which you are now under treatment and list all medications you are currently taking: ____

____
____
____

C. 1. Please check any of the following illnesses which you have had stating year of occurrence if possible:

- ☐ Arthritis (yr: ____)
- ☐ Asthma (yr: ____)
- ☐ Bronchitis (yr: ____)
- ☐ Cancer (yr: ____)
- ☐ Chickenpox (yr: ____)
- ☐ Diabetes (yr: ____)
- ☐ Eczema (yr: ____)
- ☐ Epilepsy (yr: ____)
- ☐ Gall Bladder Disease (yr: ____)
- ☐ German Measles (yr: ____)
- ☐ Gout (yr: ____)
- ☐ Hay Fever (yr: ____)
- ☐ Heart Disease (yr: ____)
- ☐ Hepatitis (yr: ____)
- ☐ Hives (yr: ____)
- ☐ Hypertension (yr: ____)
- ☐ Malaria (yr: ____)
- ☐ Measles (yr: ____)
- ☐ Meningitis (yr: ____)
- ☐ Migraine (yr: ____)
- ☐ Mumps (yr: ____)
- ☐ Nephritis (yr: ____)
- ☐ Phlebitis (yr: ____)
- ☐ Pleurisy (yr: ____)
- ☐ Pneumonia (yr: ____)
- ☐ Poliomyelitis (yr: ____)
- ☐ Renal Stones (yr: ____)
- ☐ Rheumatic Fever (yr: ____)
- ☐ Sexually Transmitted Disease (yr: ____)
- ☐ Sinusitis (yr: ____)
- ☐ Thyroid (yr: ____)
- ☐ Typhoid (yr: ____)
- ☐ TB (yr: ____)
- ☐ Tonsillitis (yr: ____)
- ☐ Ulcers (yr: ____)
- ☐ Any other: ___________ (yr: ____)

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C. 2. If you have had any of the following, state the year of occurrence, site and/or problem:

Condition	**Year**	**Site**	**Problem/ Note**
Hernias			
Concussions			
Fractures			
Dislocations			
Sprains and Strains			

C. 3. Name any illness, injury or disability not mentioned above and state year of occurrence:
____
____

C. 4. Have you ever smoked? Yes No
C. 5. Have you ever had X-Ray therapy such as for acne, Large Tonsils, etc? Yes No
C. 6. a. Have you ever consumed 3 or more cups of coffee or caffeine-containing beverage?
Yes No
C. 6. b. Have you ever consumed alcohol? Yes No If yes, describe how much and how often:
____

C. 7. If you have ever been hospitalized, state:

Date	Hospital Name	Hospital Location	Illness/ Injury/ Operation

C. 8. Have you ever received or are you receiving disability compensation? Yes No

D. If you have now, or have had any of the following symptoms or conditions, please check and underline or describe the problem. If not, leave unchecked:

- ☐ Recent changes in weight ____________________
- ☐ Insomnia (difficult to sleep) ____________________
- ☐ Fatigue, nervousness, worry or emotional disturbance that have caused loss of time from work or study ____________________
- ☐ Prolonged fever ____________________
- ☐ Dizziness, loss of consciousness or headaches ____________________
- ☐ Eye, Ear, Nose, Throat or Sinus symptoms ____________________

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continued . . .

- ☐ Impairment of sight, hearing or speech ______________________________
- ☐ Chronic cough, coughing up blood or exposure to TB ______________________________
- ☐ Chest pain, shortness of breath, palpitation, swollen ankles, heart murmur, high blood pressure ______________________________
- ☐ Leg cramps, varicose veins, varicose ulcers ______________________________
- ☐ Troublesome skin condition, i.e. hair loss, facial hair growth, rash or itching ______________________________
- ☐ Bleeding problems ______________________________
- ☐ Symptoms related to the gastrointestinal tract, i.e. recurring abdominal pain, indigestion, diarrhea, passing of blood etc. ______________________________
- ☐ Albumin, sugar or blood in urine, kidney stone or other urinary difficulties ______________________________
- ☐ Muscle, joint or back pain, bursitis sciatica ______________________________
- ☐ Benign or malignant growth or tumor ______________________________
- ☐ Thyroid problems of any kind ______________________________
- ☐ If any goiter, thyroid lump or any nodule, please answer the following questions along with any description
  - ☐ Any exposure to radiation in the past? ______________________________
  - ☐ Any difficulty in swallowing, breathing or hoarseness of voice? ______________
  - ☐ Any rapid growth or pain in the thyroid swelling? ______________________________

E. If any sensitivities (allergies) to penicillin, sulfa or other drugs or allergens: Yes No
If yes, specify ______________________________

F. [OMITTED]

G. For Men Only:
Age at Puberty _______
Circle any of the following that apply to your health now or in the past:
Pain in testes? Yes No
Lumps in testes? Yes No
Any erectile failure? Yes No
Any penile discharge? Yes No
Any ejaculation, semen or sperm problems? Yes No
Any change in libido or sexual desire? Yes No

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H. Family history

Relative	Year of Birth	Occupation	State of Health
1. Father			
2. Mother			

3. Brothers
Are brothers in good health? Yes No
If no, describe ______________________________

4. Sisters
Are sisters in good health? Yes No
If no, describe ______________________________

5. If you are married, give year of birth and state of health of the spouse: ______________________________
____

6. If any children, give their ages: ________ ________ ________ ________
Are they in good health? Yes No
If no, describe ______________________________

If family member is not living, give cause of death, age and year of occurrence: ______________________________
____
____

7. Has any blood relative had cancer, diabetes, high blood pressure, heart disease, thyroid disease, epilepsy, migraine, bleeding disorders, allergy, tuberculosis, stroke, anemia, neurological disorder, muscular dysfunction or emotional disturbance, hepatitis, AIDS, leukemia, stomach ulcer, kidney disease, arthritis, sexual dysfunction, cholesterol problem or kidney stones?
Yes No

If Yes, indicate relative and illness:

Relation	Illness

8. Do you know if your mother took estrogens (such as DES) while you were in Utero? Yes No

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9. Has any blood relative had breast cancer? Yes No
colon cancer? Yes No
thyroid cancer? Yes No
pituitary, adrenal or pancreatic cancer? Yes No

I. Your birthplace: ____
List any countries outside the USA or Canada which you have visited ____________________
____

J. Give year for the following immunizations and tests:

Diphtheria ____________________
Tetanus ____________________
Measles ____________________
Rubella____________________
Hepatitis B____________________
Pneumonia____________________
Last blood test____________________

Poliomyelitis____________________
Tuberculin skin test______________
Circle Reaction Positive Negative

Last chest X-ray______________
Last EKG____________________
Last thyroid test______________

K. When was the last physical examination done? _____/ _____/ _____ By whom: ______________
L. When was the last eye examination done? _____/ _____/ _____ By whom: ________________
M. When was the last foot examination done? _____/ _____/ _____ By whom: ________________
N. When was the last chest X-ray done? _____/ _____/ _____ By whom: ____________________
O. When was the last EKG done? _____/ _____/ _____ By whom: ___________________________

P. Please provide any other significant information relating to your health (Additional Note):
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DATE: ________________________________ SIGNATURE: ______________________________

Please hand this questionnaire to the medical receptionist after completion.

If you realize after you complete this form that any information herein needs to be corrected or updated, please advise our office immediately.

Thank you for your cooperation.