Endocrinology Patient Questionnaire

Date: _____ Patient Name: _____ DOB: _____

Primary Care Physician: _____

Current Medical History: (Briefly describe the reasons why you have come to see an Endocrinologist)

_____

_____

_____

Past Medical History: (Please check all that apply)

□Diabetes □High Blood Pressure □Thyroid Disease □Pituitary Disease □Heart Disease

□Heart Disease □High Cholesterol □Depression □Osteoporosis

□Other: _____

Please list any past surgical procedures:

_____

_____

_____

Please list any drug allergies:

_____

_____

Please list or attach a list of all current medications:

_____ _____

_____ _____

_____ _____

_____ _____

Are you taking any herbal supplements? If so, please list below.

_____

_____

Personal History:

Occupation: _____ Level of Education: _____

Marital Status: □Married □Single □Divorced □Widowed □Separated □Divorced

Do you smoke? □No □Yes: How many packs per day? _____ For how many years? _____

Alcohol History: Number of drinks per day? _____ For how many years? _____

Patient's Name: _____ DOB: _____

Diet: □Yes □No Exercise: □Yes □No

FAMILY HISTORY					
Who in your family has?	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Others**
Cancer					
Thyroid Disease					
Pituitary Disease					
Adrenal Disease					
High Cholesterol					
Diabetes					
Heart Attack					
High Blood Pressure					
Osteoporosis					

Review of Systems					
General, constitutional	**NO**	**YES**	**Musculoskeletal**	**NO**	**YES**
Good general health lately			Joint pain		
Recent weight change			Joint stiffness/swelling		
Fever			Weakness of muscles/joints		

Fatigue	NO	YES	Muscle pain or cramps	NO	YES
Eyes & Vision			Back pain		
Eye disease or injury			Cold extremities		
Wear glasses or contacts			Difficulty in walking		
Glaucoma			**Skin and breasts**		
Blurred or double vision			Rash or itching		
Ear, Nose, Throat			Chane in skin color		
Hearing loss			Change in hair or nails		
Ringing in the ears			Varicose veins		
Earaches or drainage			Breast pain		
Sinus problems			Breast lump		
Nose bleeds			Breast discharge		
Mouth sores			**Neurological**		
Bleeding gums			Frequent/recurrent headaches		
Bad breath/bad taste			Light headed or dizzy		
Sore throat/voice change			convulsions/seizures		
Swollen glands in neck			Numbness/tingling sensation		
Heart & Cardiovascular			Tremors		
Heart trouble			Paralysis		
Chest pains			Stroke		
Sudden heartbeat change			Head Injury		
Swelling of fee/ankles/hands			**Psychiatric**		
Respiratory			Memory loss or confusion		
Frequent coughing			Nervousness		
Spitting up blood			Depression		
Shortness of breath			Sleep problems		
Asthma/wheezing			**Endocrine**		
Gastrointestinal			Glandular/hormone problem		
Loss of appetite			Thyroid disease		
Change in bowel movements			Diabetes		
Nausea/vomiting			Excessive thirst/urination		
Frequent diarrhea			Heat or cold intolerance		
Painful bowel movements			Dry skin		
Blood in stool			Change in hat or glove size		
Stomach pain			**Hematologic/Lymphatic**		
Genitourinary			Slow to heal after cuts		
Frequent Urination			Easily bruise or bleed		
Burning/painful urination			Anemia		
Blood in urine			Phlebitis		
Change in force/strain w/urination			Transfusion		
Incontinence/dribbling			Swollen glands		
Kidney stones			**If you have not had a hysterectomy, please give the date of your last menstrual period: _____**		
Sexual difficulty					
Painful periods					
Irregular periods					
Vaginal discharge					