# FRIST ENDOCRINOLOGY

**NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE**

Name:______________________________________________ Date of Visit:_____/_____/_____

Date of Birth:_____/_____/_____ Social Security # _____-____-______ Chart #_____________

Referred by:____________________________ Primary Physician:__________________________

Other physicians treating you:

What is the reason for your visit?_____________________________________________________

How long have you had this problem?__________________________________________________

When was this problem discovered?___________________________________________________

How was the problem discovered?_____________________________________________________

What symptoms were/are you having related to this problem?___________________________

_____________________________________________________________________________

What is your main concern or question that you want the doctor to address at your visit?

_____________________________________________________________________________

Have you seen an endocrinologist for this? Yes____No____ Name_________________________

Address:_____________________________________________________________________

Other doctors you have seen for this problem?_________________________________________

_____________________________________________________________________________

What tests have been done for **this problem**? *Check all that apply, where performed, and results:*

☐ Blood tests __________________________________________________________________

☐ Urine tests __________________________________________________________________

☐ X-rays or Bone density test______________________________________________________

☐ CT or MRI scans ______________________________________________________________

☐ Ultrasounds __________________________________________________________________

☐ Nuclear medicine scans _________________________________________________________

☐ Biopsy _______________________________________________________________________

What treatments have you received for **this problem**? *Provide details and response to treatment:*

☐ Diet / Exercise _______________________________________________________________

☐ Vitamins/Supplements__________________________________________________________

☐ Medications _________________________________________________________________

_____________________________________________________________________________

☐ Surgery _____________________________________________________________________

☐ Other _______________________________________________________________________

# PAST MEDICAL HISTORY

**List all hospitalizations:** ☐ None ☐ Use blank sheet if more space is needed.

| *Date* | *Hospital* | *Reason* |
|---|---|---|
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |

**List all operations:** ☐ None ☐ Use blank sheet if more space is needed.

| *Date* | *Hospital* | *Operation / Reason* |
|---|---|---|
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |
| ______ | ____________________________ | ______________________________________________________ |

**Major Illnesses or Injuries:** *(Check all current or past problems. Give details and year diagnosed.)*

☐ Diabetes________________________________
☐ High blood pressure_____________________
☐ High cholesterol________________________
☐ Heart problems__________________________
☐ Circulatory problems____________________
☐ Stroke / TIA ___________________________
☐ Thyroid problem_________________________
☐ Osteoporosis / Bone problem_____________
☐ Pituitary problem_______________________
☐ Adrenal problem_________________________
☐ Parathyroid / Calcium problem___________
☐ Kidney problem / stones ________________
☐ Cancer__________________________________
☐ Lung problem____________________________
☐ Stomach / Digestive ____________________
☐ Liver problem___________________________
☐ Eye problem_____________________________
☐ Bleeding problem / Blood clots__________
☐ Arthritis_______________________________
☐ Head injury_____________________________
☐ Neurological problem____________________
☐ Mental health problem___________________
☐ Alcohol / Drug problem__________________
☐ Other___________________________________

## MEDICATIONS and ALLERGIES

**List all current medications, dosage, frequency, and how long you have taken them:**

☐ Diabetes medications:

☐ Insulin______________________________________________

______________________________________________

☐ Pills______________________________________________

______________________________________________

☐ Thyroid______________________________________________

☐ Blood pressure______________________________________________

______________________________________________

☐ Cholesterol______________________________________________

☐ Osteoporosis / Bone______________________________________________

☐ Male or Female hormones______________________________________________

☐ Pituitary or Adrenal medications______________________________________________

☐ Steroids *(pills, shots, creams, inhalers)* (in last 6 months)______________________________

☐ Heart medications______________________________________________

☐ Other medications, vitamins, and supplements:

| *Medication* | *Dose* | *Frequency* | *Reason / How Long* |
|---|---|---|---|
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| | | | |

**Allergies / Adverse reactions:** ☐ None *(Check all that apply and give details.)*

☐ Antibiotics______________________________ ☐ Osteoporosis meds______________________

☐ Diabetes meds__________________________ ☐ Blood pressure meds_____________________

☐ Cholesterol meds_______________________ ☐ Other meds______________________________

☐ Food allergies__________________________ ☐ Other allergies___________________________

## FAMILY HISTORY

**Indicate which of the following health problems run in your family?** (Blood relatives only)

| Disease/Condition | Details | Relatives (Age when problem started) |
|---|---|---|
| ☐ Diabetes / Blood sugar problem | | |
| ☐ Thyroid problems | | |
| ☐ High blood pressure | | |
| ☐ High cholesterol / triglycerides | | |
| ☐ Heart attacks / Heart problems | | |
| ☐ Circulatory problems | | |
| ☐ Strokes | | |
| ☐ Obesity / Overweight | | |
| ☐ Osteoporosis / Bone problems | | |
| ☐ Parathyroid / Calcium problems | | |
| ☐ Pituitary or Adrenal problems | | |
| ☐ Kidney problems / stones | | |
| ☐ Cancer | | |
| ☐ Birth defects | | |
| ☐ Mental health problems | | |
| ☐ Alcohol / Drug problems | | |
| ☐ Other ______ | | |

## SOCIAL HISTORY

Marital status: Single____ Married____ Divorced____ Separated____ Widowed____

Describe current living arrangement:______________________________

Education:____________________ Occupation:____________________

Describe current stress level and sources of stress:______________________________

**Health Habits:** Caffeine use: ☐ Yes ☐ No How much per day__________

Tobacco use: ☐ Never smoked ☐ Current smoker ☐ Quit (When:__________)

For current or former smokers: Years smoked_______ Packs per day_________

Alcohol use: ☐ Yes ☐ No ☐ Quit (When:__________)

How much do / did you drink in an average week?______________________________

Weight history: Weight age 21_______ Weight 5 yrs ago_______ Peak adult weight_______

Diet: Are you currently dieting? ☐ Yes ☐ No If Yes, describe diet____________________

Fast food meals per week: _______ Daily servings of: Fruits_____ Vegetables_____

Exercise: Hours per week of physical activity (yard work / house cleaning / strenuous labor)__________

Aerobic exercise (walk/jog/swim/bike/etc.): _____Minutes _____Times per week

Resistance exercise (weights/bands/etc.): _____Minutes _____Times per week

# REVIEW OF SYSTEMS

**Circle all symptoms that you have noticed recently and give details in space provided:**

**CONSTITUTIONAL** ● Weight change ● Fatigue____________________________________________

● Flushing ● Sweats ______________________________________________________________

**EYES** ● Eye pain / irritation / swelling___________________________________________________

● Vision change ● Double vision ● Blind spots __________________________________________

**EARS / NOSE / MOUTH / THROAT** ● Ringing in ears ● Loss of hearing / smell_____________________

● Pain in throat ● Hoarseness_______________________________________________________

**CARDIOVASCULAR** ● Chest pain ● Rapid heart beat_________________________________________

● Palpitations ● Leg swelling ● Leg pain when walking________________________________

**RESPIRATORY** ● Shortness of breath ● Wheezing__________________________________________

● Chronic cough ● Loud Snoring _____________________________________________________

**GASTROINTESTINAL** ● Change in appetite ● Abdominal pain ____________________________

● Swallowing problems ● Diarrhea / Constipation ____________________________________

**GENITOURINARY** ● Difficulty urinating ● Blood in urine ● Kidney stones___________________

● Irregular or missed periods ● Decreased sex drive ● Erection problems_____________________

**MUSCULOSKELETAL** ● Back pain ● Bone pain ● Fractures______________________________

● Loss of height ● Muscle pain / cramps / weakness__________________________________

**SKIN / BREAST** ● Sores that don't heal ● Rash ● Itching ● Acne___________________________

● Breast swelling / tenderness ● Milky nipple discharge________________________________

**NEUROLOGICAL** ● Headaches ● Seizures ● Fainting__________________________________

● Tremor ● Numbness / tingling in hands / feet / face______________________________________

**PSYCHIATRIC** ● Depression ● Nervousness ● Poor sleep ________________________________

● Trouble concentrating ● Memory problems _______________________________________

**ENDOCRINE** ● Frequent thirst ● Frequent urination _________________________________

● Getting up at night to urinate ● Heat / cold intolerance ● Excess facial hair_______________

● Loss of body hair ● Loss of scalp hair ● Change in skin pigmentation ___________________

**HEMATOLOGIC / LYMPHATIC** ● Anemia ● Easy bruising ● Easy bleeding ______________

● Blood clots ● Blood transfusions ● Swollen lymph nodes ________________________

**ALLERGIC / IMMUNOLOGIC** ● Asthma ● Hives ● Immune disorder___________________________

List any other bothersome symptoms: ________________________________________________

| **Office Use Only:** | Dr. Daniel | Dr. Marney | |
|---|---|---|---|
| Reviewed by: | ☐ Dr. Carlson __________ | ☐ Dr. April __________ | Date:______________ |