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_____ ☐ Cancer_____

☐ High blood pressure_____ ☐ Lung problem_____

☐ High cholesterol_____ ☐ Stomach / Digestive _____

☐ Heart problems_____ ☐ Liver problem_____

☐ Circulatory problems_____ ☐ Eye problem_____

☐ Stroke / TIA _____ ☐ Bleeding problem / Blood clots_____

☐ Thyroid problem_____ ☐ Arthritis_____

☐ Osteoporosis / Bone problem_____ ☐ Head injury_____

☐ Pituitary problem_____ ☐ Neurological problem_____

☐ Adrenal problem_____ ☐ Mental health problem_____

☐ Parathyroid / Calcium problem_____ ☐ Alcohol / Drug problem_____

☐ Kidney problem / stones _____ ☐ 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*

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: 1 Dr. Daniel _____ 1 Dr. Marney_____

Reviewed by: ☐ Dr. Carlson _____ ☐ Dr. Aprill _____ Date:_____