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: ☐ Dr. Daniel _____ ☐ Marney _____

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