advocare DELGIORNO ENDOCRINOLOGY

NEW PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

What is the reason for your visit? _____

What are your main concerns for this visit? _____

_____

Which Physician advised you to see an Endocrinologist? _____

LIST ALL OF YOUR OTHER PHYSICIANS:	SPECIALTY:
_____	_____
_____	_____
_____	_____
_____	_____

List all of your drug ALLERGIES (specify name of drug & reaction):

_____ _____ _____ _____

_____ _____ _____ _____

Preferred pharmacy: Local (name/town):_____ Mail order: _____

MEDICATIONS - Include ALL over-the-counter supplements, herbal medicines, and vitamins:
(or provide separate list)

Name of Medication	Dose (example 20 mg)	How Taken (if not oral)	Times Taken (example: one pill 3 times per day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8. .			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			

Have you used or received any steroids in the past 6 months (this includes any topical, oral, inhaled, or joint injections of steroids)? ☐ Yes ☐ No ☐ Maybe/don't know

If yes, describe: _____

Past Medical History: Please CHECK OFF any of the following problems that you have been DIAGNOSED with or have been TREATED FOR now or in the past:

Cardiovascular (Heart)

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Coronary artery disease
- stent
- heart bypass
- ☐ Heart attack; when?_____
- ☐ Peripheral artery disease
- ☐ Atrial fibrillation
- ☐ Heart murmur
- ☐ Heart valve replaced
- ☐ Other cardiac problem_____

Endocrine

- ☐ Diabetes
- ☐ Pituitary tumor
- ☐ Hypothyroidism
- ☐ Other pituitary
- ☐ Hyperthyroidism
- ☐ Adrenal nodule(s)
- ☐ Thyroid nodules
- ☐ Other adrenal
- ☐ Vitamin D deficiency
- ☐ Hyperparathyroidism
- ☐ Other endocrine_____

Cancer

- ☐ Specify type(s)_____
- ☐ Year diagnosed_____

Kidney

- ☐ Decreased kidney function
- ☐ Kidney stones
- ☐ Other kidney problem_____

Gastrointestinal

- ☐ Heartburn/reflux
- ☐ Celiac disease
- ☐ Stomach ulcer
- ☐ Pancreatitis
- ☐ Liver disease
- ☐ Hepatitis B or C
- ☐ Irritable bowel syndrome
- ☐ Diverticulosis
- ☐ Other GI problem_____

Pulmonary (Lung)

- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Sleep apnea (Do you wear CPAP? Y / N)
- ☐ Seasonal allergies
- ☐ Other lung problem_____

Rheumatologic

- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Other rheumatologic _____

Eye disease

- ☐ Glasses / contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other eye problem_____

Neurologic

- ☐ Stroke
- ☐ Seizures
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Dementia
- ☐ Parkinson's disease
- ☐ Other neurologic_____

Psych

- ☐ Depression
- ☐ Anorexia/Bulimia
- ☐ Anxiety/Panic attacks
- ☐ Bipolar disorder
- ☐ Other psych disorder_____

Infectious

- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Other infectious _____

Other

- ☐ Blood clots
- ☐ Anemia
- ☐ Skin problems _____
- ☐ Prostate problem

Have you ever had a stress test? ☐Yes ☐ No If yes, most recent & result: _____

Have you had a heart catheterization? ☐Yes ☐No If yes, most recent & result: _____

List any other problems that you have been diagnosed with, treated for, or see a physician for:

_____

_____

Past Surgical History: Please list any surgical procedures you've had and the year performed:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: (List all of your immediate family members)

Relation	Deceased (Y/N)	Current age or age of death	Medical conditions and/or cause of death
Father	☐ Y ☐ N		
Mother	☐ Y ☐ N		
Brother	☐ Y ☐ N		
Sister	☐ Y ☐ N		
Brother	☐ Y ☐ N		
Sister	☐ Y ☐ N		
	☐ Y ☐ N		
	☐ Y ☐ N		

List any family members who have the following (if not mentioned above):

Diabetes _____ Thyroid problem _____

High blood pressure _____ Thyroid cancer _____

High cholesterol _____ Osteoporosis _____

Heart disease _____ Hip fracture _____

Stroke _____ Pituitary problem _____

Kidney stones _____ Adrenal problem _____

Cancer (what types?) _____

Are there any other medical problems that run in your family? _____

_____

Does anyone in your family have a history of EARLY heart disease (before age 55 in men or 65 in women)? ☐Yes ☐No

Personal and Social History:

Marital status: ☐Never married ☐Married ☐Divorced ☐Seperated ☐Widowed ☐Other

Occupation: _____ Highest level of education you completed: _____

Number of children: _____ Ages: _____

Have you ever used tobacco products? ☐Current ☐Never ☐Quit If quit, when? _____

If yes (or quit), how many packs per day? _____ Approx years smoking? _____

How many alcoholic beverages per week do drink on average? _____

Have you ever used recreational drugs? ☐Current ☐In the past ☐Never

Do you exercise regularly? ☐Yes ☐No If yes, what do you do? _____

Women:

Last menstrual period: _____ Age of first menstrual cycle: _____

Number of pregnancies: _____ Number of births: _____

[If you have had recent imaging studies pertinent to your evaluation, please bring the actual films to your appointment. You may need to specifically ask the radiology department for the images on a CD.]

Do you have diabetes? Y N **[IF NO, SKIP TO NEXT SECTION]**
When was your last eye exam? _____
Have you ever had diabetes-related problems with your eyes? Y N
Have you ever received laser treatment for your eyes? Y N If yes, when? _____
Have you ever seen a kidney specialist? Y N
Have you had diabetes-related problems with your kidneys? Y N
Have you ever seen a podiatrist? Y N If yes, when? _____
Do you suffer from numbness or tingling in your feet or legs? Y N
Have you ever had foot ulcers or foot infections? Y N
Have you ever received a pneumonia vaccine? Y N If yes, when? _____
Do you typically receive flu shots yearly? Y N

Review of systems: While many people have some of the symptoms listed below from time to time, please check off those symptoms that you are having CURRENTLY, are of INCREASED FREQUENCY, are RECURRING, or that cause you concern:

	Yes	No		Yes	No		Yes	No
Weight loss			Abdominal pain			Dizziness		
Weight gain			Change in bowels			Numbness/tingling		
Fatigue			Constipation			Seizures		
Fevers			Diarrhea			Intolerance to heat		
Loss of appetite			Rectal bleeding			Intolerance to cold		
Headache			Nausea/vomiting			Excessive thirst		
Blurry vision			Heartburn/reflux			Hair changes		
Double vision			Frequent urination			Excessive bleeding/bruising		
Hearing problems			Other urinary difficulty			Recurrent infections		
Neck swelling			Back pain					
Voice change/hoarseness			Joint pain			WOMEN:		
Difficulty swallowing			Depressed mood			Change in periods		
Chest pain			Anxiety			Decreased sex drive		
Palpitations/heart racing			Insomnia					
Leg swelling			Rash			MEN:		
Cough			Other skin changes			Decreased sex drive		
Shortness of breath			Breast tenderness			Problems with erections		
Excessive snoring			Breast discharge					

Other: _____
_____
_____
_____