

## 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:

<p><b>Cardiovascular (Heart)</b></p> <p><input type="checkbox"/> High blood pressure      <input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> Coronary artery disease      stent      heart bypass</p> <p><input type="checkbox"/> Heart attack; when? _____</p> <p><input type="checkbox"/> Peripheral artery disease      <input type="checkbox"/> Atrial fibrillation</p> <p><input type="checkbox"/> Heart murmur      <input type="checkbox"/> Heart valve replaced</p> <p><input type="checkbox"/> Other cardiac problem _____</p> <p style="text-align: center;"><b>Cancer</b>    <input type="checkbox"/></p> <p><input type="checkbox"/> Specify type(s) _____</p> <p><input type="checkbox"/> Year diagnosed _____</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Heartburn/reflux      <input type="checkbox"/> Celiac disease</p> <p><input type="checkbox"/> Stomach ulcer      <input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Liver disease      <input type="checkbox"/> Hepatitis B or C</p> <p><input type="checkbox"/> Irritable bowel syndrome      <input type="checkbox"/> Diverticulosis</p> <p><input type="checkbox"/> Other GI problem _____</p> <p><b>Rheumatologic</b></p> <p><input type="checkbox"/> Arthritis      <input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> Rheumatoid arthritis      <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Osteoporosis      <input type="checkbox"/> Osteopenia</p> <p><input type="checkbox"/> Other rheumatologic _____</p> <p><b>Neurologic</b></p> <p><input type="checkbox"/> Stroke      <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Migraines      <input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Dementia      <input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Other neurologic _____</p> <p><b>Infectious</b></p> <p><input type="checkbox"/> HIV/AIDS      <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Other infectious _____</p>	<p><b>Endocrine</b></p> <p><input type="checkbox"/> Diabetes      <input type="checkbox"/> Pituitary tumor</p> <p><input type="checkbox"/> Hypothyroidism      <input type="checkbox"/> Other pituitary</p> <p><input type="checkbox"/> Hyperthyroidism      <input type="checkbox"/> Adrenal nodule(s)</p> <p><input type="checkbox"/> Thyroid nodules      <input type="checkbox"/> Other adrenal</p> <p><input type="checkbox"/> Vitamin D deficiency      <input type="checkbox"/> Hyperparathyroidism</p> <p><input type="checkbox"/> Other endocrine _____</p> <p><b>Kidney</b></p> <p><input type="checkbox"/> Decreased kidney function      <input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Other kidney problem _____</p> <p><b>Pulmonary (Lung)</b></p> <p><input type="checkbox"/> Emphysema/COPD      <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Sleep apnea (Do you wear CPAP? Y / N)</p> <p><input type="checkbox"/> Seasonal allergies</p> <p><input type="checkbox"/> Other lung problem _____</p> <p><b>Eye disease</b></p> <p><input type="checkbox"/> Glasses / contacts</p> <p><input type="checkbox"/> Cataracts      <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Other eye problem _____</p> <p><b>Psych</b></p> <p><input type="checkbox"/> Depression      <input type="checkbox"/> Anorexia/Bulimia</p> <p><input type="checkbox"/> Anxiety/Panic attacks      <input type="checkbox"/> Bipolar disorder</p> <p><input type="checkbox"/> Other psych disorder _____</p> <p><b>Other</b></p> <p><input type="checkbox"/> Blood clots      <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Skin problems _____</p> <p><input type="checkbox"/> Prostate problem</p>
<p>Have you ever had a stress test?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, most recent &amp; result: _____</p> <p>Have you had a heart catheterization?    <input type="checkbox"/> Yes    <input type="checkbox"/> No    If yes, most recent &amp; result: _____</p>	
<p>List any other problems that you have been diagnosed with, treated for, or see a physician for:</p> <p>_____</p> <p>_____</p>	

**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	<input type="checkbox"/> Y <input type="checkbox"/> N		
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N		
Brother	<input type="checkbox"/> Y <input type="checkbox"/> N		
Sister	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> Y <input type="checkbox"/> N		
	<input type="checkbox"/> Y <input type="checkbox"/> 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  Separated  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: \_\_\_\_\_

**[Please bring any bloodwork results and radiology imaging of your thyroid (the actual films) to your appointment. You may need to ask the radiology department specifically for the images on a CD to bring with you, as well as the report.]**

Have you had exposure to radiation in the past (except routine x-rays)? Y N Not sure  
 Have you had a CAT scan (of any body part) in the last 3 months? Y N With dye? Y N Don't know  
 Have you had recent exposure to large doses of iodine (such as kelp)? Y N  
 Have you been prescribed lithium, amiodarone, or interferon recently? Y N  
 Any difficulty swallowing? Y N  
 Any change in your voice or hoarseness? 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		
Increased appetite			Nausea/vomiting			Excessive thirst		
Headache			Heartburn/reflux			Hair changes		
Blurry vision			Frequent urination			Excessive bleeding/bruising		
Double vision			Other urinary difficulty			Recurrent infections		
Hearing problems			Back pain					
Neck swelling			Joint pain			WOMEN:		
Chest pain			Depressed mood			Change in periods		
Palpitations/heart racing			Anxiety			Decreased sex drive		
Leg swelling			Insomnia					
Cough			Rash			MEN:		
Shortness of breath			Other skin changes			Decreased sex drive		
Excessive snoring			Breast tenderness			Problems with erections		
			Breast discharge					

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_