

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>Cardiovascular (Heart)</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;">Cancer</p> <p><input type="checkbox"/> Specify type(s) _____</p> <p><input type="checkbox"/> Year diagnosed _____</p> <p style="text-align: center;">Gastrointestinal</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 style="text-align: center;">Rheumatologic</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 style="text-align: center;">Neurologic</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 style="text-align: center;">Infectious</p> <p><input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Other infectious _____</p>	<p style="text-align: center;">Endocrine</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 style="text-align: center;">Kidney</p> <p><input type="checkbox"/> Decreased kidney function <input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Other kidney problem _____</p> <p style="text-align: center;">Pulmonary (Lung)</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 style="text-align: center;">Eye disease</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 style="text-align: center;">Psych</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 style="text-align: center;">Other</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 & result: _____</p> <p>Have you had a heart catheterization? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, most recent & 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 and all relevant bloodwork and imaging studies with you to your appointment.]

- Have you ever had a brain or pituitary MRI? Y N
 - Have you suffered any major head trauma in the past? Y N
 - Do you have new headaches (or of increased frequency)? Y N
 - Do you have trouble with peripheral (side) vision? Y N
 - Any exposure to radiation, chemotherapy, or environmental toxins? Y N
 - Any problems in the past with fertility? Y N
 - Any abnormal hair growth or loss? Y N
 - Any breast tenderness, enlargement, or discharge? Y N
 - Have you ever used testosterone supplements or other steroids? Y N
 - Any history of testicular trauma, tenderness, or mass? Y N
 - Any history of mumps infection? Y N
 - Do you have any erectile dysfunction? Y N
- On a scale of 1-10, how would you rate your libido (10 is highest)? _____

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			Cough			Depressed mood		
Weight gain			Shortness of breath			Anxiety		
Fatigue			Excessive snoring			Insomnia		
Fevers			Abdominal pain			Rash		
Loss of appetite			Change in bowels			Other skin changes		
Blurry vision			Constipation			Dizziness		
Double vision			Diarrhea			Numbness/tingling		
Hearing problems			Rectal bleeding			Seizures		
Neck swelling			Nausea/vomiting			Intolerance to heat		
Voice change/hoarseness			Heartburn/reflux			Intolerance to cold		
Difficulty swallowing			Frequent urination			Excessive thirst		
Chest pain			Other urinary difficulty			Hair changes		
Palpitations/heart racing			Back pain			Excessive bleeding/bruising		
Leg swelling			Joint pain			Recurrent infections		

Other: _____

