Date:

NEW ENDOCRINE PATIENT HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**	**AGE:**
Referring doctor and previous endocrinologist (if any):	**Date of last physical exam:**	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Have you ever had any of the following(please explain):

DIABETES: _____NO YES_____IF YES: WHAT YEAR WAS IT DIAGNOSED?_____
BODERLINE DIABETES: _____NO YES_____
GESTATIONAL DIABETES: _____NO YES_____
DIABETIC RELATED EYE DAMAGE (RETINOPATHY) : ___ NO YES_____
NEUROPATHY: _____NO YES_____
KIDNEY PROBLEMS: _____ NO YES_____

HYPERTENSION(HIGH BLOOOD PRESSURE) : _____NO YES_____
HIGH CHOLESTEROL: _____NO YES_____
HEART PROBLEMS/HEART ATTACK: _____NO YES_____

LOW/HIGH THYROID LEVELS (HYPO- OR HYPERTHYROIDISM): _NO YES_____
THYROID NODULES/CANCER: _____NO YES_____
ANY HISTORY OF RADIOACTIVE IODINE TREATMENT: __NO YES_____
ANY THYROID ULTRASOUNDS DONE: _____NO YES_____

PITUITARY PROBLEMS: _____NO YES_____
ADRENAL PROBLEMS: _____NO YES_____

THYROID OR PITUITARY SURGERY: _____NO YES_____

OSTEOPOROSIS/OSTEOPENIA:_____NO YES_____
BONE MINERAL DENSITY: _____NO YES_____

PAST RADIATION OF ANY KIND: _____ NO YES_____

PLEASE LIST ANY OTHER MEDICAL PROBLEMS:

Surgeries (list any types of surgeries)

SOCIAL HISTORY

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	☐ Yes	☐ No
	# of meals you eat in an average day?		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per day?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes – pks./day ☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Occupation status:	☐ Retired ☐ Student ☐ Part-time ☐ Full-time ☐ Other		
Type of work:			

FAMILY HEALTH HISTORY

ANY FAMILY HISTORY OF DIABETES?: _____ NO YES_____
ANY FAMILY HISTORY THYROID DISEASE?: __NO YES_____

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

SYMPTOMS QUESTIONNAIRE

Name *(Last, First, M.I.):*	**Date:**

Please circle those symptoms that you have apply:

General: Feeling unwell Fevers Chills Night Sweats Weight Gain Weight Loss Change in Appetite

Skin: Dry Skin Brittle Nails Bruising Excessive Hair Growth Hair Loss Other nail changes

Head: Headache Blurred Vision Puffiness around the eyes Visual Disturbances Loss of Vision
Sleep Apnea Trouble with Smell Voice Changes Choking sensation.

Neck/Thyroid: Neck Lump Neck Swelling Neck tenderness in the front of the neck

Respiratory: Dry Cough Chronic Cough Difficulty Breathing Wheezing Shortness of Breath.

Cardiovascular: Chest Pain Elevated Blood Pressure Palpitations Shortness of Breath
Swollen Ankles

Gastrointestinal: Abdominal Pain Constipation Diarrhea Food Intolerance Indigestion
Nausea Vomiting

Reproductive: Loss of sex drive Men – Problems with Erections Women – Irregular Periods
Women- Difficulties Getting Pregnant

Musculoskeletal: Joint Pain Muscle loss Muscle Weakness Feet problems

Neurological: Headaches Pins and Needles sensation Tremors Weakness Sleepy during the day

Psychiatric: Anxiety Depression Inability to Concentrate Mood changes.

Endocrine: Appetite Changes Cold Intolerance Excessive Sweating Excessive Thirst Excessive Urination
Heat Intolerance Libido Change Drinking excessive water Urinating excessively
Having to go to the bathroom to urinate at night Abnormal nipple discharge

DO YOU HAVE ANY OTHER SYMPTOMS OR PROBLEMS OTHER THAN THE ABOVE? NO YES

IF YES, PLEASE
EXPLAIN_____
_____
_____
_____
_____
_____
_____