New Patient Questionnaire – General Endocrine

Name ______________________________ Date _____ Primary Care Physician _______________

What is the reason for this appointment? ____

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Illness/Medical History	Self	Family	Details
Diabetes			
Heart Disease			
Kidney Disease			
Thyroid Disease			
Adrenal Disorder			
Pituitary Disorder			
Stroke			
Cancer			
High Cholesterol			
High Blood Pressure			
Osteoporosis			
Other			

Please list any previous surgeries and their dates. ____

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Please list all medications, including over the counter and herbal medications with doses, if known.

______________________ ______________________ ______________________

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Are you allergic to any medications? ____

M.D. Initials: ____________

PLEASE MAKE SURE TO COMPLETE BOTH SIDES OF THIS INFORMATION SHEET.

Social History

Do you smoke or have you smoked in the past? ______________________________

Do you drink alcohol? How much? ______________________________

Review of Systems

Please circle any current symptoms you are experiencing.	
General	fatigue, general weakness, weight loss, weight gain, abnormally thirsty
Head	visual difficulty, double vision, blurred vision, change of voice, painful swallowing, difficulty swallowing
Neck	neck pain, swelling
Heart	chest pain, shortness of breath with exertion, rapid heart beating
Lungs	shortness of breath, cough
Gastrointestinal	abdominal pain/discomfort, nausea, vomiting, diarrhea, constipation
Urinary	Frequent daytime urination, nighttime urination, frequent urinary or vaginal infections
Reproductive	difficulty with erections, pregnant, post menopause Date of last menstrual period: __________
Skin	rash, dry skin, moist skin, thin skin, easy bruising
Blood	prolonged bleeding, other blood disorders
Endocrine	intolerance to heat, intolerance to cold
Musculoskeletal	calf cramping, previous foot ulcer, previous fracture, osteoporosis
Neurological	burning/numbness/tingling of feet, tremulousness, jitteriness
Psychological	depression, anxiety

M.D. Initials: ____________

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