ASSOCIATED ENDOCRINOLOGISTS

NEW PATIENT QUESTIONNAIRE

Patient Name: ____ Patient's Date of Birth: ____________________

Name of Parent or Guardian (if patient is a minor): __________________________________ Contact Phone: ___________________

What is the primary reason for your visit? ____

❑ Thyroid ❑ Diabetes ❑ Other Endocrine (please describe): ___________________

Depending upon the reason for your visit, please answer the questions below:

Please list any recent tests you have had (blood tests, ultrasound, scan, radioactive iodine therapy, HbA1c, etc.,) and results, if known:

TEST	RESULT	TEST	RESULT

Have you had any surgery related to your condition? Yes ___ No ___ If so, please explain: __________________________________

If you have had any scans or surgeries, please indicate where and when:

Surgery/Procedure	Date	Location

MEDICAL HISTORY

Illness/Medical History	**Self**	**Family**	**Details (relationship, how long ago, etc.)**
Diabetes			
Heart disease			
Kidney disease			
Thyroid disease			
Adrenal disorder			
Pituitary disorder			
Stroke			
Cancer			
High cholesterol			
High blood pressure			
Osteoporosis			
Other (please describe)			

M.D./D.O./N.P. Initials: ________

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS INFORMATION FORM

Please list all medications you are taking, including over the counter and herbal medications, with doses, if known:

Name of Medication	Dosage	Reason for taking

Name of Medication	Dosage	Reason for taking

Are you allergic to any medications? If so, please list: ____

Females: Have you ever been pregnant? Yes _____ No _____ If so, when was your last pregnancy? ___________________

SOCIAL HISTORY

Do you work? Yes _____ No _____ If yes, what is your occupation? ____

Do you smoke, or have you smoked in the past? Yes _____ No _____ If a former smoker, when did you quit? _____________

Do you consume alcohol? Yes _____ No _____ If yes, approximately how much? ___________________________________

Do you use recreational drugs? Yes _____ No _____ If yes, please describe: _______________________________________

REVIEW OF SYSTEMS

Please ***circle*** *any current symptoms you are experiencing.*

General	fatigue, general weakness, weight loss, weight gain, abnormal thirst
Head	visual difficulties, double vision, blurred vision, voice changes, 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, hair loss
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

Diabetes patients only:

When were you first diagnosed with diabetes? __________ Who else in your family has diabetes? _____________________________

Are you any kind of a special diet? Yes ____ No ____ If so, please describe: ____

Do you exercise regularly? Yes ___ No ___ When did you last see an eye doctor? _____ When did you last see a foot doctor? ______

List the typical range of your blood sugars ***before***:

Breakfast: _____________ Lunch: ________________ Dinner: _________________ Bedtime: ______________

Do you currently use an insulin pump? Yes ____ No ____ If so, what model pump do you use? ________________________________

If you do not currently use an insulin pump, are you interested in information about using them? Yes _____ No _____

What is the name of your glucose monitor? ______________________

M.D./D.O./N.P. Initials: ________

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