ASSOCIATED ENDOCRINOLOGISTS
A DIVISION OF MHP

New Patient Questionnaire

Patient Name: _____ Date of Birth: _____ 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:

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)			

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 or blurred vision, voice changes, painful or difficulty swallowing
Neck	neck pain, swelling
Lungs	shortness of breath, cough
Heart	chest pain, shortness of breath with exertion, rapid heart beating
Gastro-intestinal	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

<u>Diabetes patients only:</u>

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

Are you on 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? _____ 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? _____