Date of Visit:_____ENDOCRINOLOGY NEW PATIENT

Patient name: _____ Primary Care provider: _____

Date of birth: _____ Consult requested by: _____

Other physicians: _____

Pharmacy name/location: _____

Reason for visit today: _____

Personal & Family Medical History	**I** have this. ***Please include year diagnosed	A **family member** has this. *Please note relationship		**I** have this. ***Please include year diagnosed	A **family membe**r has this. *Please note relationship
Diabetes ● Type 1 ● Type 2			High prolactin levels		
Complications from Diabetes ● Eye problems ● Kidney problems ● Nerve problems			Low testosterone		
			Adrenal nodules		
			Adrenal insufficiency (low cortisol)		
High blood pressure			Prescribed steroids		
High cholesterol			Last menstrual period ● # of pregnancies ● # of births		
Prior heart disease? Prior heart attack? Prior heart surgery or stents? Prior stroke or TIA? Irregular heartbeat?			Polycystic ovarian syndrome (PCOS)		
			Vision problems		
			Frequent headaches		
			Seizures		
Hypothyroidism (low thyroid)			Sleep apnea		
Hyperthyroidism (high thyroid)			Heartburn/reflux		
Thyroid nodules ● Prior biopsy?			Depression/anxiety		
Osteoporosis			Colitis/Crohn/celiac disease		
Parathyroid disease			Arthritis		
Kidney stones			Blood clots in lungs or legs		
Pituitary tumor			Hepatitis/liver problems		
Other:			Lupus		
			Emphysema/COPD		
			Cancer ● Please specify type		

Surgeries	Please list year

Medication Name	Dose	How many times per day?

Allergies

Any allergies to medications? Yes No *Please list medication and reaction

_____

_____

Social History

Marital status: Single Married Domestic partnership Divorced Widowed

Do you have children? Yes No Number of children: _____

Occupation: _____

Education completed: High school Some college College degree Graduate degree Other

Hobbies: _____

Do you exercise? Yes No How many times per week? _____

Do you smoke? Yes No

If Yes, how many packs each day?_____ When did you start smoking? _____

If No, have you ever smoked? Yes No When did you quit smoking? _____

Do you drink alcohol? Yes No How many per week? _____

Do you use recreational drugs? Yes No Which one(s)? _____

Immunizations

Are your immunizations up to date? Yes No

When was your last flu vaccine? This year Last year >1 year ago Never

When was your last pneumonia vaccine? _____

Which pneumonia vaccines have you received? Prevnar (PCV-13) Pneumovax (PCV-23)

Please circle any symptoms you have noticed in the last year

Constitutional
Fever
Weight loss
Weight gain
Fatigue

Eyes
Vision changes
Eye pain
Eye dryness

Ears, Nose, Mouth, Throat
Hearing loss
Ear pain
Ear discharge
Nasal drainage
Sinus pressure
Sore throat/Hoarseness
Snoring
Difficulty swallowing

Cardiovascular
Chest pain
Shortness of breath during exertion
Palpitations
Leg Swelling

Respiratory
Shortness of breath
Cough
Wheezing
Sleep apnea

Gastrointestinal
Nausea
Vomiting
Diarrhea
Constipation
Heartburn
Change in appetite

Office Use Only

Ht: _____ Wt: _____ BP: _____/_____

BMI: _____ HR: _____ SpO2: _____ RR: _____

Genitourinary
Painful urination
Frequent urination
Vaginal discharge
Difficulty emptying bladder
Irregular Cycles
Getting up at night to urinate
Erection problems
Decreased libido

Musculoskeletal
Joint swelling
Back pain
Muscle pains
Muscle weakness

Integumentary
Rash
Dry skin
Change in skin pigment

Neurological
Headaches
Weakness
Numbness in hands/feet
Dizziness
Memory loss/Problems concentrating

Psychiatric
Depression
Anxiety
Insomnia

Metabolic
Excessive thirst
Excessive urination
Cold intolerance
Heat intolerance
Unwanted hair growth
Hair loss

Hematologic
Swollen lymph nodes
Easy bruising
Easy bleeding

Immunologic
Seasonal allergies
Food allergies
Itching

If you have **Diabetes**, please answer the following:

	Yes	**No**			**Yes**	**No**
Do you check blood sugar at home? ● How often?				Have you taken Diabetes Education classes?		
When was your last eye exam?				Do you follow a diabetic diet?		
What **diabetes** medications have you used before, but are not currently taking?				Do you have any recurrent infections or slow healing wounds?		
Any other problems related to your diabetes?				Do you have a personal or family history of pancreatitis, multiple endocrine neoplasia or medullary thyroid cancer?		
Do you have frequent bladder infections?				Do you have frequent yeast infections?		

If you have **Thyroid** problems, please answer the following:

	Yes	**No**			**Yes**	**No**
Have you had radiation treatments to your neck??				Do you have any pain or swelling in the front of your neck?		
Do your eyes bulge?				Do you have any problems swallowing?		
Do you have any double vision?				Are you hotter or colder than others around you?		

If you have **Osteoporosis, Osteopenia,** or **Parathyroid** problems, please answer the following:

	Yes	**No**			**Yes**	**No**
Have you broken any bones? Which ones?				Do you eat milk/cheese/yogurt daily?		
Have you fallen in the last year? How many times?				When was your last bone density test?		
What was your height as a young adult?				Do you have problems getting out of a chair?		
Do you take calcium or vitamin D? How much?				Do you use antacids frequently?		
Do you have bone pain?				Do you have abdominal pain?		
Do you need any major dental work (other than routine cleaning)?				Did either of your parents have a broken hip?		
Are you taking steroids now? Or previously took for 3+ months?						

If you have **Adrenal** problems, please answer the following:

	Yes	No			Yes	No
Do you have spells with headache, racing heart, and seating ALL at the same time?				Do you have problems getting out of a chair?		
Do you ever have a low potassium?				Do you have any purple stretch marks?		
Have you taken steroid medication recently?				Do you have hard to control blood pressure or diabetes?		

If you have **Another** endocrine problem (pituitary, hormone replacement), please answer the following:

	Yes	No			Yes	No
Is your voice deeper than it used to be?				Do have leakage from your nipples?		
Is your nose wider than it used to be?				Do you have increased acne?		
Are your hands or feet bigger than they used to be?				Do you have vaginal dryness?		
Do you have any problems with peripheral vision?				Do have painful intercourse?		
Do you have night sweats?				Are you able to reach orgasm?		
Do you have hot flashes?				Do you have sleep apnea?		
Has it been more than 6 months since your last period?				Any problems conceiving pregnancy?		
You have more than 4 weeks between periods?						

Any other problems you wish to discuss?

Clinician Notes: