CHANDLER ENDOCRINOLOGY

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Patient Name: _____ **Date:** _____

Review of Systems

Please circle yes or no to each of the following questions below:

	General
Yes No	Do you have problems with fevers?
Yes No	Any increase or decrease in appetite?
Yes No	Have you had any increase or decrease in weight in the last year?
Yes No	Do you have fatigue that prevents you from doing daily activities?
Yes No	Do you have trouble sleeping?
	Eyes
Yes No	Do you have double or blurry vision?
Yes No	Do you have excessive tearing of your eyes?
Yes No	Do you have any bulging of your eyes?
Yes No	Do you have eye pain?
Yes No	Any problems with your peripheral vision?
Yes No	Do you have sensitivity to sunlight?
	Ears, Nose, Throat
Yes No	Do you have decreased hearing?
Yes No	Do you have clear fluid coming from your nose?
Yes No	Do you have any trouble smelling aromas like coffee?
Yes No	Has your voice been persistently hoarse?
Yes No	Have you had any other changes in your voice?
Yes No	Do you have trouble swallowing?
	Cardiovascular
Yes No	Are you having trouble with chest pain?
Yes No	Do you have chest pressure or tightness when walking or working?
Yes No	Does your heart race or thump?
Yes No	Do you have leg cramps when walking?
Yes No	Have you ever felt faint or passed out?
	Lungs
Yes No	Do you snore?
Yes No	Has your family ever said you stop breathing while you sleep?
Yes No	Any shortness of breath when laying flat?
	Gastrointestinal
Yes No	Do you have frequent nausea or vomiting?
Yes No	Do you have constipation?
Yes No	Do you have diarrhea or frequent bowel movements?
Yes No	Have you ever had jaundice or liver failure?

	Skin
Yes No	Are you bothered with frequent skin rashes?
Yes No	Do you have excessive perspiration?
Yes No	Do you have night sweats or hot flashes?
Yes No	Do you have any problems with your fingernails or toenails?
Yes No	Have you noticed any changes in the color of your skin?
Yes No	Have you experienced any loss of body hair?
Yes No	Have you experienced excessive unwanted hair growth?
Yes No	Do you experience dry skin?
	Neurological
Yes No	Do you have frequent headaches?
Yes No	Do you have numbness, tingling, or pain of the hands or feet?
Yes No	Do you experience any hand or foot spasms or cramps?
Yes No	Do you suffer from any tremors or shaking of your hands?
	Psychiatric
Yes No	Do you have any history of mental problems?
Yes No	Do you have any restlessness?
Yes No	Do you have any anxiety?
Yes No	Do you suffer from uncontrolled depression?

	Endocrine
Yes No	Do you experience excessive thirst?
Yes No	Do you have excessive urination?
Yes No	Do you feel hot or cold in a room that is comfortable for others?
Yes No	Have you ever had any broken bones?
Yes No	Do you have problems with low blood sugar?
Yes No	Do you have problems with high or low blood pressure?
Yes No	Do you have persistent and frequent salt cravings?
	Musculoskeletal
Yes No	Do you have frequent muscle cramps?
Yes No	Do you have trouble standing from a seated position?
Yes No	Do your arms get tired when doing task above your head?
Yes No	Have you lost strength in your arms or legs?
	Genitourinary
Yes No	Do you regularly get up more than once from sleeping to urinate?
Yes No	Do you have trouble starting urination?
Yes No	Have you ever had kidney stone?
Yes No	Do you have a reduced sex drive?
Yes No	(Women Only) Do you have vaginal dryness?
Yes No	(Men Only) Do you have problems obtaining or maintaining an erection?

Family History: Please specify if any blood relatives have had any of the following:

Condition	No	Yes	Specify (Relative and Type)
Diabetes			
High Cholesterol			
High Blood Pressure			
Heart Problems			
Thyroid Problems			
Osteoporosis			
Kidney Disease			
Asthma/COPD			
Osteoarthritis			
GERD/Acid Reflux			
Mental Illness			
If other, please specify:			

Social History: Do you now or have you ever used the following?

Item	Yes	No	Specify Type, How much (daily, weekly, Etc) and How long (Years, Months, Etc.)
Alcohol			
Illicit Drugs (specify)			
Caffeine (Coffee, Tea; specify)			
Tobacco			

Previous Surgeries:

Type: _____ **Date:** _____ **Type:** _____ **Date:** _____
Type: _____ **Date:** _____ **Type:** _____ **Date:** _____

Medications ☐ **None** ☐ **List Attached**

Medication Name	Dose	How Often Taken