Endocrinology Patient Intake Form

M13

Patient Name _____ DOB _____ Age _____ Date _____

Primary Care Physician _____ Referring Physician _____

PLEASE ANSWER ALL QUESTIONS

What is your reason for today's visit? _____

1. When did the problem/discomfort start? _____
2. Where is the problem/discomfort located? _____
3. What makes it worse? _____
4. If there are any other symptoms associated with this problem please describe _____
5. Have you been under the care of any other physician for this problem? _____

GENERAL REVIEW OF SYSTEMS Are you currently having any of the following symptoms? (Please circle yes or no)

Constitutional:
Y N Weight Gain
Y N Weight Loss
Y N Night Sweats
Y N Fever
Y N Fatigue

Eyes:
Y N Blurred/impaired vision
Y N Dry Eyes

ENT:
Y N Hearing loss
Y N Sore throat
Y N Bleeding gums
Y N Voice change
Y N Difficulty swallowing
Y N Swollen Neck

Cardiovascular:
Y N Chest pains/discomfort
Y N Palpitations/racing heart beat
Y N Swelling of feet, ankles or hands

Respiratory:
Y N Frequent coughing
Y N Sputum productive cough
Y N Shortness of breath
Y N Asthma or wheezing
Y N Snoring

Gastrointestinal:
Y N Loss of appetite
Y N Change in bowel movements
Y N Nausea
Y N Vomiting
Y N Frequent diarrhea
Y N Constipation
Y N Stomach pain
Y N Heartburn

Genitourinary:
Y N Frequent urination
Y N Burning or painful urination
Y N Blood in urine
Y N Incontinence or dribbling
Y N Kidney stones
Y N Sexual difficulty
Y N Erection Problems

Musculoskeletal:
Y N Joint pain
Y N Joint stiffness or swelling
Y N Weakness of muscles/joints
Y N Muscle pain or cramps
Y N Back pain
Y N Cold extremities
Y N Leg pain with walking
Y N Leg swelling
Y N Limb weakness

Skin:
Y N Rash
Y N Itching skin
Y N Change in skin color
Y N Easily bruise
Y N Non-healing sores
Y N Excessive Hair Growth
Y N Hair loss
Y N Dry skin
Y N Darkening of skin
Y N Brittle hair
Y N Brittle nails

Psychiatric:
Y N Memory loss or confusion
Y N Nervousness
Y N Depression
Y N Sleep problems
Y N Suicidal thoughts
Y N Anxiety

Neurological:
Y N Syncope/Passing out
Y N Near Syncope
Y N Headaches
Y N Lightheaded
Y N Dizziness
Y N Convulsions or seizures
Y N Numbness or tingling
Y N Tremors
Y N Paralysis

Endocrine:
Y N Thyroid disease
Y N diabetes
Y N Excessive thirst
Y N Excessive urination
Y N Heat Intolerance
Y N Cold intolerance
Y N Dry skin
Y N Infertility
Y N Excessive sweating
Y N Decrease in appetite
Y N Increase in appetite
Y N Discharge from nipples

Hematologic/Lymphatic:
Y N Slow to heal after cuts
Y N Bleeding tendencies

Adverse Reactions to:
Y N Penicillin or antibiotics
Y N Morphine, Demerol, narcotics
Y N Novocain, other anesthetics
Y N Aspirin or other pain remedies
Y N Tetanus antitoxin, other serum
Y N Iodine, methiolate, antiseptics

Patient Signature_____ **Date**_____

Please See Reverse Side

Thank you for completing all questions

Please list all PRESCRIPTION medications that you take

Name	Dose	Frequency

List all OVER THE COUNTER medications and supplements that you take

Name	Dose	Frequency

List all allergies that you have:

_____
_____
_____
_____
_____

Past Medical History: (Check all that apply)

_____ Heart Disease	_____ Thyroid Disease	_____ COPD	_____ Cancer
_____ Heart Valve Problems	_____ Liver Disease	_____ Kidney Disease	_____ Bleeding Disorder
_____ Heart Failure	_____ High Cholesterol	_____ Stroke	_____ Hepatitis(A,B or C)
_____ HIV Disease/exposure	_____ Lung Problems	_____ Diabetes	_____
_____ Previous Heart Attack	_____ Emphysema		_____
_____ High Blood Pressure	_____ Asthma		_____

Please provide information about previous surgeries and hospitalizations (include date or year)

Surgeries / Procedures		Hospitalizations	
_____	Date_____	Admitted for _____	Date_____
_____	Date_____	_____	Date_____
_____	Date_____	_____	Date_____
_____	Date_____	_____	Date_____
_____	Date_____	_____	Date_____
_____	Date_____	_____	Date_____
_____	Date_____	_____	Date_____

Family History

Father	Age _____	Disease(s) _____	Cause of death, if deceased _____
Mother	Age _____	Disease(s) _____	Cause of death, if deceased _____
Siblings	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____
_____	Age _____	Disease(s) _____	Cause of death, if deceased _____

Social History:

Cigarette Smoking: ↑Never ↑Current: _____ pack(s) per day, _____ year's total ↑Previous: _____ year quit
Use of Alcohol: ↑Never ↑Rare/Social ↑Moderate ↑Daily: amount per day _____ ↑Previous: _____ year quit
Use of Caffeine: ↑Never ↑Rare/Social ↑Moderate ↑Daily: amount per day _____ ↑Previous: _____ year quit
Exercise Level: ↑Never ↑Rare ↑Moderate ↑Daily _____ times per week. Type of exercise: _____
Special Diet: ↑Low Fat ↑Low Cholesterol ↑Vegetarian ↑Other _____
Employment: ↑Full time ↑Part time ↑Retired ↑Unemployed ↑Other _____

Patient Signature_____ **Date**_____