Endocrine Consultants of Texas
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PATIENT QUESTIONNAIRE: PLEASE USE ADDITIONAL PAGES IF NEEDED

Please tell us your reason for this visit. What sort of problems are you having and how long has this bothered you:

_____
_____
_____
_____

Referring MD: _____ Primary Care MD: _____
tel.:_____ tel.:_____
Age:_____Sex:_____Ethnicity:_____Race:_____ Language:_____
Education:_____ Occupation: _____
No.of Children:_____Ages of Children: _____
Allergies/drug reactions: to what and what type of reaction you had: _____
_____
Do you smoke:_____how many cigarettes per day: _____For how long: _____
Do you drink alcohol?_____How many drinks per day:_____For how long: _____

Family history: indicate who in your family had following/any other medical conditions:

Diabetes: _____ Hypoglycemia: _____Gestational Diabetes: _____
ThyroidDisease_____Goiter/ThyroidNodules_____
Neck Radiation_____ Low calcium_____High calcium_____
Kidney disease_____Kidney stones_____Bone problems _____
Stomach problems_____Liver disorders _____
Polycystic ovaries_____ Infertility_____ Congenital Defects _____
Stroke_____ Heart Disease_____ Circulation problems _____
Lung Disease_____Mental Illness_____ Blood disorders_____
Cancer/what type_____
Any other conditions:_____

Please indicate if you have/had any of the following medical problems and since when:

Diabetes:_____Hypoglycemia_____ Diabetes during pregnancy _____
Underactive thyroid_____ Overactive thyroid_____ Goiter/Thyroid Nodules _____
Low calcium _____High calcium_____Bone problems _____Kidney stones_____
Kidney disease_____ Adrenal disease_____ Pituitary disease _____
Stomach/intestinal problems _____Liver disorders_____Skin problems_____
Polycystic ovaries _____ Infertility_____ Congenital Defects _____
Stroke _____ Heart Disease _____ Circulation problems_____
Lung Disease_____Mental Illness_____ Blood disorders/Anemia_____
Cancer/what type_____
Any other conditions: _____
_____

Please indicate all surgeries, traumas, deliveries, fractures and hospitalizations that you had:

Condition	YEAR	PLACE	DOCTOR

_____

What pharmacy do you use for medications _____Tel._____

Current Medications, including dosages:

_____
_____
_____
_____

Do you now have difficulties with any of the following, if yes for how long?

___Weight gain_____lb
___Weight loss_____lb
___ Increased sweating
___ Dry skin
___Itching
___Skin rashes
___Hair loss
___Excessive hair growth/where _____
___Acne
___Headaches
___Fever
___Eye pains
___Visual blurring
___Double vision
___Difficulties with peripheral vision
___Cataracts
___Other vision problems
___Dizziness
___Difficulty hearing
___Nose bleeds
___Trouble with smell/taste
___Pain/pressure in the throat
___Difficulty swallowing
___Changes in the voice
___Dental problems
___Cough
___Wheezing
___Shortness of breath
___Chest pain/pressure
___Irregular/fast heart beats
___High/low blood pressure
___Do any foods bother you/how?_____
_____
___Nausea
___Vomiting
___Abdominal pain
___Gallbladder problems
___Jaundice
___Diarrhea
___Constipation
___Bloody/black stools
___Cold intolerance

___Sexually transmitted diseases
___ Urethral/vaginal discharge
___Burning on urination
___Frequent urination
___Getting up at night to urinate_____times
___Losing urine when you cough/sneeze
___ Urinary infections/last time_____
___Difficulty starting urinary stream
___Back pain
___Pains in muscles/bones/joints
___Swelling/redness in joints
___ Legs/arms pains/cramps
___ Dizziness on arising from lying position
___Numbness in legs/arms
___Difficulty with balance
___Head/back/neck injury
___Transient blindness
___Paralysis/Weakness of arms/legs
___Seizures/Shaking of arms/legs
___Anxiety
___Difficulties falling/staying asleep
___Depression
___Mood swings
___Fatigue
___Dehydration
___Increased thirst
___Hunger/shakiness/irritability if late for meal
___Cravings of sweets/salts
___Heat intolerance/hot all time
___Recent increase in size of your hands/feet
___Darkening of the skin
___Easy bruising
___Prolonged bleeding
___Frequent infections
___ Decreased libido
___Trouble with fertility
___Breast pain/discharge

Men only:
___Problems initiating erections
___Problems maintaining erections
___Delay in puberty
___Do you have biological children? age _____

For your most recent health maintenance information, please mark all that applies to you:

ECG date _____ /normal/abnormal
CXR date_____ /normal/abnormal
Pap smear _____/normal/abnormal
Bone density test_____/normal/abnormal
Stress test_____/normal/abnormal
Dilated eye exam_____/normal/abnormal
Mammogram _____/normal/abnormal
Prostate exam_____/normal/abnormal
PSA test_____/normal/abnormal
Colonoscopy_____/normal/abnormal

Women only:
Age at onset of menstrual period_____ years
___Duration of cycle____days, regular/irregular
___Heavy/light flow
___Bleeding between periods
___Premenstrual breast tenderness, abdominal bloating/mood changes
Number of pregnancies_____Deliveries_____
Complications of pregnancy_____
Age, birth weight, sex of each child_____
Contraceptive/hormone therapy_____
___Hot flashes Age at menopause_____Age at Hysterectomy_____

Additional questions for Patients with Diabetes
How long have you had diabetes?_____
Do you have eye damage/retinopathy?_____ Had eye surgery?_____
When did you have your last eye exam?_____
Do you have kidney damage from diabetes?_____
Do you have nerve damage from diabetes/describe?_____
Do you have difficulty with wound healing?_____
Have you ever had ketosis/diabetes coma?_____
Do you have increased thirst? _____Frequent urination?_____ Headaches after heavy meals? _____
Do you experience low blood sugars?_____How often and when during the day: _____
_____
What oral medications do you use for diabetes/how often: _____
_____
If on insulin what is the type/dose and timing of injections:_____
_____
Do you rotate injection sites?____ How often you forget to take your medications? _____
Did you receive diabetes education by Diabetes Educator/Dietician?_____
Do you do carbohydrate counting? _____ What diet do you follow? _____

Describe your typical breakfast: _____

Lunch: _____

Dinner: _____

_____
Snack:
_____
_____