Rockville Internal Medicine Group ENDOCRINOLOGY QUESTIONNAIRE

Printed Patient Name:_____ **Date of Birth:** _____
REASON FOR VISIT: _____ **Today's Date:** _____
Referring Physician: _____

Please bring all relevant X-rays, CAT scans (disc or film) as well as other diagnostic reports to your first visit.

MEDICAL HISTORY: (Mark All that Apply)

Thyroid	**Diabetes**
Hypothyroidism (underactive Thyroid)	Age at Diagnosis:
Hyperthyroidism (overactive Thyroid)	Symptoms at Diagnosis:
Thyroid Nodule – Date Diagnosed:	Date started Medication:
Thyroid Cancer – Date Diagnosed:	Date started Insulin:
Heart	Retinopathy
High Blood Pressure	Date of Last Eye Exam
High Cholesterol	Laser Therapy
Heart Attack	Neuropathy
Heart Failure	Increased Urinary Protein
Angioplasty / Stent	**Cancer**
Atrial Fibrillation / Flutter	No Yes Type:
Stroke	**Neuro / Psychiatric**
Lung	Seizures
Asthma	Neuropathy
COPD / Emphysema	Stroke
Sleep Apnea	Migraine
Other:	Eating Disorder
Bone	Alcoholism
Osteopenia	Addiction
Osteoporosis	Depression
Hip Fracture	Anxiety
Spine Fracture	Other:
Wrist Fracture	**GYN**
GI	Date of First Period Regular Irregular
Hepatitis	How Many Pregnancies
Celiac Disease	Last Period
GERD/Reflux	Hormone Replacement
Gallstones	**Other Medical Conditions**
Other:	1.
Kidney Disease	2.
Abnormal Kidney Function	3.
Dialysis	4.
Kidney Transplant	5.
Kidney Stones	6.

SURGICAL HISTORY: (Mark All that Apply and Indicate Date Performed)

Heart Bypass	Gallbladder
Angioplasty/Stent	Thyroid Surgery
Leg Bypass	Pituitary Surgery
Hip Replacement	Other Surgeries:
Hysterectomy	1.
Ovaries Removed: yes no	2.
	3.

CURRENT MEDICATIONS :

NAME	DOSE	FREQUENCY	INDICATION

MEDICATION ALLERGIES: _____ **No Known Allergies** If yes, complete below:

Drug Name	Reaction

SOCIAL HISTORY:

Marital Status: _____ Children: ___ Girls _____ Boys

Occupation: _____

Smoking: Current Maximum packs/day_____

Former Number of years smoked _____ Year quit _____

Never

Alcohol: _____ Drinks per week

Caffeine: _____ per day

Exercise type and frequency: _____

Special Diet / Type / Restrictions: _____

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY: (Mark All that Apply and List Family Member)

	Family Member			Family Member
Diabetes:			Thyroid Nodule	
Adult Onset/Type II			Goiter	
Juvenile Onset/Type I			Thyroid Cancer	
High Blood Pressure			Calcium Disorder	
High Cholesterol			Parathyroid Disease	
Heart Attack			Osteoporosis	
Stroke			Hip Fracture	
Hypothyroid/Underactive			Kidney Stones	
Hyperthyroid/Overactive			Adrenal Disease	
Cancer			Pituitary Disease	
Other:			Other:	

REVIEW OF SYMPTOMS: (Mark All that Apply)

General	**Cardiovascular**	**Genitourinary**
Weight Gain	Chest Pain	Pain with Urination
lbs. in months/yrs.	Heart Attack	Frequent Urination
Weight Loss	Heart Murmur	Blood in Urine
lbs. in months/years	Palpitations	Urinating Overnight
Sleeping Problems	Irregular Heart Beat	Number of times per night
Fatigue	Shortness of Breath w/Walking	Hesitation with Urination
Fevers/Chills/Sweats	Dizziness	Incomplete Voiding
Skin	Swelling of Feet/Ankles	Lack of Bladder Control
Skin Rash	**Gastrointestinal**	**Men:**
Itching	Nausea / Vomiting	Erectile Dysfunction
New Skin Marks/Spots	Vomiting Blood	Changes in libido
Head/Eyes/Ears/Nose/Throat	Difficulty Swallowing	Fertility problems
Visual Problems / Changes	Heartburn/Indigestion	Pain or changes in Penis/Testicles
Type:	Abdominal Pain	Testicular Mass / Breast Lump
	Constipation / Diarrhea	**Women:**
Voice Changes	Reflux / Bloating	Premenopausal
Sinus Infections	**Neurological / Psychiatric**	Perimenopausal
Hoarseness	Headache / Light-headedness	Postmenopausal
Sore Throats	Numbness / Tingling	Irregular Periods
Headaches	Dizziness / Vertigo / Fainting	Fertility Problems
Respiratory	Balance Problems / Falling	Prior Pregnancy
Coughing	Changes in Mood	Prior Miscarriage/Abortion
Wheezing	Concentration/Memory changes	Nipple Discharge
Shortness of Breath	Anxiety / Depression	Hot Flashes
Bone / Muscle	**Endocrine**	**Endocrine (Continued)**
Joint Pain	Excessive Thirst	Feeling of lump in neck
Muscle Pain	Excessive Urination	Tremor
Bone Pain	Intolerance to heat/cold	Low Blood Sugar Reaction
Back Pain	Changes to Skin/Hair/Nail	Frequency:
Other:	Describe:	Other:

Patient Signature: _____ Date: _____