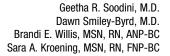




ENDOCRINOLOGY PATIENT INTAKE FORM

Patient Name:	Date of Birt	th: Today's Date:			
Reason for Current Visit:					
Referring Physician:	Phone:	Fax:			
Are you currently pregnant?	If so, how many weeks?				
PAST MEDICAL HSITORY: Please circle	all that apply				
Depression	CHF	Seizure Disorder			
Diabetes Type I	COPD	Stroke			
Diabetes Type II	Coronary Artery Disease	TIA			
Hyperlipidemia (High Cholesterol)	Crohn's Disease	Cancer - Breast			
Hypertension (High Blood Pressure)	Cushing's Disease	Cancer - Cervical			
Hyperthyroidism	GERD	Cancer - Colon			
Hypothyroidism	HIV	Cancer-Prostate			
Hypocalcemia	Kidney Stone	Cancer-Thyroid			
Hypercalcemia	Cirrhosis	Cancer other-			
Pituitary tumors	Hepatitis	Osteoarthritis			
Thyroid Disorder	Low Testosterone	Other:			
Acromegaly	Osteopenia				
Anemia	Osteoporosis				
Anxiety	PCOS				
Asthma	Rheumatoid arthritis				
Autoimmune Disorder	Seasonal Allergies				





Patient Name:							
PAST SURGICAL HISTORY: PI	lease circle all th	nat apply an	d date of surgery				
Bypass Surgery			Anesthesia Problems	YES	NO		
Pacemaker/Defibrillator			Surgical Complications	YES	NO		
Stent/Angioplasty			Post Op Delirium	YES	NO		
Thyroidectomy			Other:				
Gastric Bypass			if so when				
FAMILY HISTORY: Please cir	cle all that apply	1					
l am adopted	yes		Both Parents			Brother	Sister
Diabetes	Mother	Father	Both Parents			Brother	Sister
Thyroid Disease	Mother	Father	Both Parents			Brother	Sister
Thyroid Nodules	Mother	Father	Both Parents			Brother	Sister
Hyperthyroidism	Mother	Father	Both Parents			Brother	Sister
Hypothyroidism	Mother	Father	Both Parents			Brother	Sister
Alcoholism	Mother	Father	Both Parents			Brother	Sister
Anemia	Mother	Father	Both Parents			Brother	Sister
Arthritis	Mother	Father	Both Parents			Brother	Sister
Anxiety	Mother	Father	Both Parents			Brother	Sister
Asthma	Mother	Father	Both Parents			Brother	Sister
Blood Clots	Mother	Father	Both Parents			Brother	Sister
Depression	Mother	Father	Both Parents			Brother	Sister
Growth Develop/Disorder	Mother	Father	Both Parents			Brother	Sister
Headaches	Mother	Father	Both Parents			Brother	Sister
Heart disease	Mother	Father	Both Parents			Brother	Sister
Hypertension	Mother	Father	Both Parents			Brother	Sister
High Cholesterol	Mother	Father	Both Parents			Brother	Sister
Osteoporosis	Mother	Father	Both Parents			Brother	Sister
Seizures	Mother	Father	Both Parents			Brother	Sister

Father

Mother

Cancer: _





Patient Name:			
Glucose Monitored:	YES	NO	If yes, last reading;
Dietary Changes:	Low Fat	Low Salt	Counting Carbs Weight Reduction Diet Other:
Do you exercise regularly?	YES	NO	How many times per week?
Types of exercise:			
SOCIAL HISTORY: please circle	all that ap	ply:	
Single Married Widowed	Divorced	d Separat	red
Occupation:			Education:
RISK FACTORS:			
Do you use tobacco?	YES	QUIT:	(year) NEVER
If currently smoking cigarettes,	how many	packs per d	ay?
If currently smoking cigars, how	many per	week?	
Do you drink alcohol?	YES	NO	How many drinks per day?
Do you drink Caffeine?	YES	NO	How many caffeinated beverages per day?
MEDICATIONS: List all medicati	ons you ar	e currently t	aking:
MEDICATION		DOSE	HOW OFTEN
			
ALLERGIES: List medication alle	rnies and r	eactions (Hiv	ves Swelling FTC)
ALLEMAND. LIST MODIFICATION AND	igioo ana i	odotiono (m	roo, orrolling, £10.)
			