ENDOCRINOLOGY NEW PATIENT FORM

Name:___________________________ **Primary Care Physician:** ____________________

What is the best way to contact you: □ Phone ________________ OR □ Email: Follow My Health
If by phone, can we leave a detailed message: □ Yes □ No

Retail Pharmacy: ___________________ **Mail Order Pharmacy:** ___________________

List the problem(s) which has led to the referral to our endocrine clinic:

___________________________ ___________________________ ___________________________

Review of Systems: Check any of those problems which you are currently experiencing:

General
- ☐ Weight changes Amount: ________
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Skin
- ☐ Skin Rash
- ☐ Itchiness
- ☐ Purple stretch marks
- ☐ Darkened skin areas

Eyes
- ☐ Double or blurred vision
- ☐ Eye Irritation
- ☐ Bulging/Swelling of Eyes
- ☐ Diabetic Retinopathy

Cardiovascular
- ☐ Pain in chest
- ☐ Palpitations (racing heart)
- ☐ Leg Swelling (Edema)

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Increasing constipation
- ☐ Stomach pain

Genitourinary
- ☐ Frequent urination
- ☐ Sexual dysfunction
- ☐ Irregular Menses

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle Pains

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness or sensitivity of feet/fingers
- ☐ Dizziness/ Light headedness
- ☐ Fainting

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Endocrine
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hair growth
- ☐ Hair loss
- ☐ Goiter
- ☐ Breast/Nipple Discharge
- ☐ Change in hand/ring size or shoe size

For Women Only:

Age when periods began:_______

Periods regular? □ Yes □ No

Have you gone through menopause? □ Yes (age: ______) □ No

Do you plan to get pregnant in the near future? □ Yes □ No

Number of pregnancies? ______

Number of miscarriages? ______

Please list your medication allergies and reaction to them:

Please list your medications: (include supplements, herbal medicines, vitamins):

Social History:

Are you married or with a partner? _______________ **Do you have any children?** _________

Occupation: _______________

Do you exercise? ☐ Yes ☐ No

If yes, how many days per week at a moderate level (like a brisk walk) or greater: ___________

How many minutes each time: _____________

Do you smoke tobacco? ☐ Yes (per day:________________) ☐ Former ☐ No

Do you drink any alcohol? ☐ Yes (drinks per day:___________) ☐ Former ☐ No

Do you use recreational drugs? ☐ Yes (type:________________) ☐ Former ☐ No

You do not need to fill this page out if the information is already in your electronic chart

MEDICAL HISTORY: Check if you have (or had in the past) any of the following conditions:

	Pertinent details (date diagnosed, type of condition, etc.)
Diabetes	
High Blood Pressure	
High Cholesterol	
Heart Problems or Bypass Surgery	
Stroke	
Thyroid Problems	
Kidney Problems	
Cancer	
Osteoporosis	

Please list any surgeries you have had:

Type of Surgery and Date:

FAMILY HISTORY: check if any of your family members have any of the following conditions:

	Yes	No	Which Family Member, any details
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Problems or Bypass Surgery			
Stroke			
Thyroid Problems			
Kidney Problems			
Osteoporosis			
Cancer			
Other			