DOYLESTOWN THYROID & ENDOCRINE ASSOCIATES

NEW PATIENT HEALTH QUESTIONAIRE

NAME:_____ AGE:_____ DATE OF VISIT:_____

What is the chief reason you are being seen today? _____

Please list all medical problems or surgeries for which you have been diagnosed or treated:

SYMPTOM REVIEW: (We recommend that you also discuss any symptoms with your regular doctor)

Please circle Y (yes) or N (no) for any of these symptoms that have bothered you *recently*:

General:		**Gastrointestinal:**		**Endocrine:**	
fatigue	Y N	abdominal pain	Y N	cold or heat intolerance	Y N
fevers	Y N	nausea	Y N		
general weakness	Y N	vomiting	Y N	**Muscle/Bone:**	
weight gain	Y N	diarrhea	Y N	joint pain	Y N
weight loss	Y N	constipation	Y N	broken bones	Y N
HEENT:		**Genitourinary:**		**Psychological:**	
eyesight problems	Y N	difficulty urinating	Y N	depression	Y N
trouble swallowing	Y N	pain urinating	Y N	anxiety	Y N
hoarseness	Y N	menstrual irregularity	Y N		
headaches	Y N	erectile dysfunction	Y N	**Hematological:**	
				bruising	Y N
Heart/Lung:		**Neurological:**		bleeding	Y N
chest discomfort	Y N	numbness	Y N		
irregular heart	Y N	tingling	Y N	**Skin:**	
short of breath	Y N	weakness	Y N	dry skin	Y N
cough				rash	Y N
				acne	Y N

SOCIAL ISSUES:

Do you smoke? YES Packs per day _____ Age when started _____ NO

Do you drink alcohol? Yes No How many drinks/day? 0 ½ 1 2 3 4 or more

Do you use illicit drugs? Yes No

What is your occupation? _____

CURRENT MEDICATIONS:

Name of Medication	Dosage	Name of Medication	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medication? Yes No If yes, list: _____

FAMILY MEDICAL HISTORY:

Is there a family history (blood relatives only) of the following conditions? If so, circle and list how the family member is related to you. (i.e. mother/father/sister/brother/grandparent, etc)

Diabetes _____ Heart Disease _____
Cancer _____ Specify type of cancer_____
Osteoporosis _____
Thyroid _____ Adrenal/pituitary _____
Any other diseases which run in the family? Please describe: _____

FOR DIABETES PATIENTS ONLY: (skip the rest of this form if you do not have diabetes)

How long have you had diabetes? _____		
Have you ever been hospitalized for diabetes?	YES	NO
How any times a day do you check your sugar? _____		
What is the range of numbers you see? _____		
Have you needed help from another person to recover from a low blood sugar?	YES	NO
Do you have a glucagon emergency kit?	YES	NO
Do you have numbness, tingling or pain in your feet or legs?	YES	NO
Have you had a flu shot this year?	YES	NO
Have you ever had a vaccination for pneumonia?	YES	NO
When was the last time you saw an eye doctor for a diabetes eye exam? _____		
Who is your eye doctor? _____		
Have you ever been told of bleeding or diabetic changes in your eyes?	YES	NO
Have you ever had a heart attack or been told you have coronary artery disease?	YES	NO
Do you take a daily aspirin?	YES	NO

Thank you!
Doylestown Thyroid & Endocrine Associates