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/week? 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