LAUREL ENDOCRINE & THYROID SPECIALISTS, P.A.
PATIENT QUESTIONNAIRE

Instructions: Please answer all questions to the best of your ability. Check all questions asking yes or no answers appropriately, but leave blank if you are not sure. Leave comments blank as these will be filled in by the providers.

DATE: _____
NAME: _____
ADDRESS: _____
_____

A. GENERAL HEALTH (circle) Excellent Good Fair Poor

B. PAST MEDICAL HISTORY:

	Yes	No	Year	Complications	Comments
Cancer					
Diabetes					
Blood Disorders					
Heart Disease					
Kidney Disease					
High Blood Pressure					
Liver Disease					
Glandular Disorders					
Skin Disease					
Neurologic Disorders					

OTHER ILLNESSES AND/OR SURGERY: (Please list illness or surgery, year, and complications)

Illness or Surgery	Year	Complications	Comments

ALLERGIES: (List all drugs or substances to which you are allergic and specify type of reaction (i.e. itching, rash, hives, wheezing, swelling, etc.)

Allergy	Reaction

PATIENT NAME: _____

HABITS:

	Yes	No	How much (per day/per week)
Cigarettes/Cigars/Pipe			
Alcohol			
Drugs (Specify)			

CURRENT MEDICATIONS: (List all medications and supplements which you take regularly)

Medication	Amount per day

PAST MEDICATIONS: (List all medication and supplements you have taken in the last 6 months.)

Medication	Amount per day

C. FAMILY HISTORY:

	Age	State of health (if deceased, cause of death)
Father		
Mother		

Brothers	Sisters	Age	State of health (if deceased, cause of death)

Male Children	Female Children	Age	State of health (if deceased, cause of death)

PATIENT NAME: _____

Have any relatives had the following:

	Yes	No	If yes, what relation?	Comments
Diabetes				
High Blood Pressure				
Heart Disease				
Kidney Disease				
Strokes				
Hardening of the arteries				
Arthritis or Rheumatism				
Goiter				
Cancer				
Seizures				

D. REVIEW OF SYSTEMS: Please check yes or no as deemed appropriate regarding the following symptoms. If you are not sure, please leave blank. Leave comments blank.

NO	YES	GENERAL	COMMENT
		Weakness	
		Tiredness: Early morning	
		Late afternoon	
		Weight change	
		Chills	
		Fever	
		Night sweats	
		Difficulty in sleeping	

NO	YES	EYES, EARS, NOSE, THROAT	COMMENT
		Decreased ability to see	
		Blurred vision	
		Pain in the eyes	
		Difficulty in hearing	
		Sinus trouble	
		Hoarseness	
		Pain in the neck	

NO	YES	RESPIRATORY	COMMENT
		Cough	
		Shortness of breath	
		Pain in the chest	

PATIENT NAME: _____

NO	YES	CARDIOVASCULAR	COMMENT
		Chest pain, tightness, or squeezing	
		Shortness of breath when lying down	
		Need to sit up to breathe	
		Heart racing	
		Irregular heart beat (palpitations)	
		Heart murmur	
		Swelling of the legs	
		Varicose veins	
		Leg pain at rest	
		Leg pain with exertion	
		Blue or purple discoloration of hands/feet	

NO	YES	BREASTS	COMMENT
		Lumps	
		Pain	
		Discharge	

NO	YES	GASTROINTESTINAL	COMMENT
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Abdominal pain	
		Bright red blood in stools	
		Black stools	
		Change in bowel habits	
		Food intolerance	
		Need for antacids	
		Hemorrhoids	

NO	YES	URINARY	COMMENT
		Urinary tract infections	
		Pain or burning on urination	
		Frequent urination	

PATIENT NAME: _____

NO	YES	GENITO-REPRODUCTIVE (Male)	COMMENT
		Discharge from penis	
		Testicular pain	
		Lumps in testicles or scrotum	
		Decrease in testicular size	
		Decreased sexual desire	
		Decreased ability to achieve erection	

NO	YES	GENITO-REPRODUCTIVE (Female)	COMMENT
		Age of onset of menstrual periods	
		Age which periods stopped (menopause)	
		How far apart are your periods?	
		How many days do they last?	
		Is flow heavy, scanty, or normal? (Circle)	
		Do you ever bleed between periods?	
		Does intercourse cause you undue pain?	
		Do you have decreased sexual desire?	
		Any vaginal bleeding since menopause?	
		Are you bothered by hot flashes?	
		Are you taking any female hormones?	

NO	YES	OBSTETRICAL	COMMENT
		Pregnancies: Full term deliveries	
		Miscarriages	
		Stillbirths	
		Complications: High blood pressure	
		Toxemia	
		Severe hemorrhage	
		Diabetes	
		Any children over 9 lbs	
		Other (please indicate)	

PATIENT NAME: _____

NO	YES	MUSCULOSKELETAL	COMMENT
		Painful joints	
		Swelling of any joints	
		Redness of any joints	
		Stiffness of any joints	
		Deformities of joints/extremities	
		Muscle pain	
		Back pain	
		Pain down the back of your legs	

NO	YES	ENDOCRINE	COMMENT
		Goiter	
		Heat intolerance	
		Cold intolerance	
		Tremulousness of the hands	
		Change in pitch of voice	
		Increased body hair (face, underarms, pubic)	
		Decreased body hair (face, underarms, pubic)	
		Loss of periods (disregard if normal menopause)	
		Increased thirst	
		Marked increase in appetite	

NO	YES	SKIN	COMMENT
		Dryness of skin	
		Change in skin color	
		Falling out of the hair	
		Skin ulcers	