Alliance Endocrinology

New Patient Questionnaire

Name: ____**Today's Date:** __________________________

DOB: _____/_____/___________**Age:** __________ **Primary care physician (PCP):** ______________________________

Referring physician (if different than your PCP) ____

Your preferred pharmacy/address/Phone number: ____

Mail order pharmacy: ____

Reason for today's visit: ____

Allergies (Drugs, food, environment,etc)	Reaction
1.	
2.	
3.	

Medications (include supplements, vitamins and herbs)-Dose and Frequency/Prescriber	Medications (include supplements, vitamins and herbs)-Dose and Frequency/Prescriber
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Health conditions or problems-check (√) conditions you have or have had in the past

- ❑ Aids or HIV
- ❑ AFIB
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Back Problems
- ❑ Bladder Infections
- ❑ Bleeding disorders
- ❑ Blood Transfusions
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Celiac disease
- ❑ COPD
- ❑ Depression
- ❑ Eczema
- ❑ Epilepsy
- ❑ Diabetes
- ❑ Fractures
- ❑ GERD
- ❑ Gestational diabetes
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart attack
- ❑ Heart failure
- ❑ Heart stents
- ❑ Hepatitis
- ❑ Hernia
- ❑ High Blood pressure
- ❑ High cholesterol
- ❑ Kidney stones
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mumps
- ❑ Obesity
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Peptic ulcer
- ❑ Prostate problem
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid Problem
- ❑ Tuberculosis
- ❑ Vaginal infections

List Dates

□**Last Physical**_____________

□**Last lab draw**_____________

□ **Sleep study if done/Date**_________________

□ **Bone Density (DXA) if done/Date**_________________

If you are here for Diabetes visit

□**Glucometer brand**______________

□**Diabetes education**_____________

□**Last dilated eye exam**___________

□**Last foot exam**________________

□**Dental Exam**__________________

□**Last Flu shot**_________________

□**Last Pneumonia shot**___________

□**Any cardiac stress test**__________

□**Any Vascular studies**____________

□**Ophthalmologist**_______________

□**Podiatrist**____________________

To the best of my knowledge the above information is complete and correct. I Understand that it is my responsibility to inform my doctor if I ever have a change in health.

Signature of the patient/ personal representative_________________________Print Name______________________________Date_____________

Reviewed by________________________________Date_____________________

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Please list any other medical conditions not mentioned:		
1.	3.	5.
2.	4.	6.

Check Operations performed / year performed:

□Angioplasty /	□Carotid artery surgery/	□Ear Surgery/	□Hysterectomy/	□Sinus/	□Thyroid /
□Appendectomy/	□Carpel tunnel surgery/	□Eye surgery/	□Knee surgery/	□Stomach/	□Trauma related/
□ Bladder surgery/	□coronary bypass/	□Gall bladder surgery/	□Neurosurgery/	□Tonsillectomy/	□Other_________
□ Breast surgery/	□Chest/Lung surgery/	□Hip surgery/	□Ovary removed/	□Tubal ligation/	□
□ Back/Neck surgery/	□C-section/	□Hernia surgery/	□Prostate/	□Vascular surgery/	□

Hospitalizations if any:

Year	Hospital	Reason for hospitalization/Outcome

Social History:

Marital Status: □ single □ married □ Divorced____/______/______□ Widowed______/_____/______
Number of children:__________________________Highest level of education: _________________________
Occupation:________________________□ Retired_____________□ Active________________
Physical Activity/Exercise:___________________________Frequency:
Smoking □ No □Yes: type and amount_________________________________Number of Years______________
If former smoker, date quit: ____
Alcohol □ No □Yes type and amount:_____________________________________Number of years___________
When was your last drink_________________________If quit- date_________________________________
Caffeine □ No □Yes Type_______________ Street Drugs: □ No □Yes Type _______________If Quit- date_____

Family History- Please check (√) if any family members have the conditions below

Relationship	cancer	Diabetes	Drugs/ Alcohol	Heart Disease	Kidney Disease	Obesity	stroke	Thyroid	High cholesterol	High Blood Pressure	Osteoporosis
Mother											
Father											
Sister											
Brother											
Daughter											
Son											
Mat. Aunt											
Mat. Uncle											
Pat. Aunt											
Pat. Uncle											
M.Grandmother											
M.Grandfather											
P.Grandmother											
P.Grandfather											

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Review of Systems- Check (√) symptoms you currently have: *Please check only current symptoms*

General
- ❑ Change in appetite
- ❑ Fatigue
- ❑ Poor concentration
- ❑ Memory Loss
- ❑ Generalized Weakness/Tiredness
- ❑ Weight gain
- ❑ Weight loss

Eyes /Head
- ❑ Blurred vision
- ❑ Double vision
- ❑ Peripheral vision loss
- ❑ Eye Pain
- ❑ Severe headaches

Gastrointestinal
- ❑ Change in bowel habits
- ❑ Indigestion/Heart burn
- ❑ Nausea/Vomiting
- ❑ Abdominal pain
- ❑ Bloating/Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Black stools
- ❑ Rectal bleeding

Musculoskeletal
- ❑ Back pain
- ❑ Pain in the joints
- ❑ Frequent muscle spasms
- ❑ Stiffness
- ❑ Difficulty arising from a chair/climbing stairs

Psychology
- ❑ Anxious
- ❑ Depressed

Hematology/Lymphatic
- ❑ Bruise easily
- ❑ Swollen glands

Skin
- ❑ Sores that don't heal
- ❑ Purple stretch marks
- ❑ Severe dry skin
- ❑ New facial hair
- ❑ Itching
- ❑ Rash
- ❑ Change in moles

Respiratory
- ❑ Shortness of breath
- ❑ Persistent cough
- ❑ Wheezing
- ❑ Excessive snoring
- ❑ Bloody sputum

Endocrine
- ❑ Excessive thirst
- ❑ Hair loss
- ❑ Sensitivity to heat
- ❑ Sensitivity to cold

Allergies/Immune
- ❑ Seasonal allergies

Men only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Poor sex drive
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Lump in testicles
- ❑ Decrease force/flow /dribbling
- ❑ Difficulty initiating urine stream

Genito-Urinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful Urination
- ❑ Poor Sex Drive

Ears-Nose-Mouth-Throat
- ❑ Bleeding gums
- ❑ Difficulty swallowing
- ❑ Ear ache /Discharge
- ❑ Loss of hearing
- ❑ Hoarseness
- ❑ Neck masses
- ❑ Nose bleeds
- ❑ Sore Throat
- ❑ Loss of Smell

Cardiovascular
- ❑ Chest pain or discomfort
- ❑ Irregular heart beat
- ❑ Rapid heart rate
- ❑ Poor circulation
- ❑ Swelling of ankles
- ❑ Varicose veins

Neurology
- ❑ Numbness/ tingling/ in hands or feet
- ❑ Tingling around lips of fingertips
- ❑ Tremors
- ❑ Dizziness
- ❑ Insomnia
- ❑ Black outs

Women Only
- ❑ Breast lump
- ❑ Breast discharge
- ❑ Age periods began_________
- ❑ How many days in between_________
- ❑ Is flow heavy______________
- ❑ How many days do they last________
- ❑ Extreme menstrual pain/Cramps
- ❑ Bleeding between periods
- ❑ Hot flashes
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Abnormal pap smear
- ❑ Date of last Menstrual period______________
- ❑ Date of last pap smear____________
- ❑ Date of last mammogram___________
- ❑ Birth Control If any/type_______________
- ❑ Age of Menopause__________

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Reviewed by_________________________________Date______________________