NEW PATIENT QUESTIONAIRRE

Please complete this prior to your appointment and fax in advance to 602-258-9933.
*** Please also bring the completed form to your appointment**

GENERAL INFORMATION:

Name:______________________ Language(s) Spoken:______________

Address:____

Daytime Phone #: ______________ Cell Phone #: ______________

Date of Birth: _____/_____/_____ Age:_____ Email Address: ______________

Can we contact you at this address for medical issues? ❑ Yes ❑ No

Ethnicity: ❑ Hispanic ❑ Non Hispanic

Race: ❑ Caucasian ❑ Black ❑ Asian ❑ Indian
❑ Native American ❑ Other ______________

REFERRING DOCTOR:

NAME	ADDRESS	PHONE NUMBER/FAX NUMBER
		/

❑ Adrenal Issues	❑ Diabetes Type 1	❑ Diabetes Type 2
❑ Diabetes in Pregnancy	❑ Hyperthyroidism	❑ Hypothyroidism
❑ Osteoporosis	❑ PCOS	❑ Prediabetes
❑ Thyroid Cancer	❑ Pituitary	❑ Other ______________

ALLERGIES: ❑ No Known Allergies

MEDICINE	REACTION

SURGICAL HISTORY Please list surgeries you have had, date and hospital ❑ **None**

Surgery	Date	Location

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MEDICATIONS/SUPPLEMENTS		
Name of Medication/Supplement	Dosage	Date Started
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL HISTORY Check if you have or have ever had these conditions

CARDIAC
- ❑ High Blood Pressure
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Irregular Heart Beat
- ❑ Mitral Valve Prolapse
- ❑ Peripheral Vascular Disease
- ❑ Stroke

RESPIRATORY
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Emphysema

MUSCULOSKELETAL
- ❑ Arthritis
- ❑ Other _____________

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Irritable Bowel
- ❑ Constipation
- ❑ Diverticulitis
- ❑ Crohns/Colitis

GENITOURINARY/REPRODUCTIVE
- ❑ Many Urine Infections
- ❑ Kidney Stones
- ❑ Infertility

Males:
- ❑ Erectile Dysfunction

Females:
- ❑ Gestational Diabetes
- ❑ Irregular Periods
- ❑ Date of Last Period:______________
- ❑ PAP ______________
- ❑ Mammogram______________

HEMATOLOGIC
- ❑ Easy Bleeding/Bruising
- ❑ Hx of Blood Clot

NEUROLOGIC
- ❑ Spine/Back Injury
- ❑ Seizures
- ❑ Migraines
- ❑ Recurrent Headaches

CANCER
- ❑ Type ______________________

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid
- ❑ Osteoporosis
- ❑ High Cholesterol
- ❑ Steroid Use
- ❑ Excessive Weight Gain
- ❑ Pituitary

Females:
- ❑ Polycystic Ovary Syndrome
- ❑ Unwanted Facial or Body Hair

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FAMILY HISTORY – are you adopted? ❑ Yes ❑ No
Have any of your family members ever had any of the following? (Please cross out any family listed below that does not apply to you, ie – if you do not have a brother, cross out Brother.

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Negative Hx	Other
Arthritis-Rheum										
Arthritis*Osteoporosis										
Asthma										
Cancer										
Diabetes										
Heart Failure										
High Cholesterol										
Hypertension										
Migraines										
Rashes/Skin*Problems										
Seizures										
Stroke										
Thyroid Disease										

REVIEW OF SYSTEMS – please check if you are currently experiencing any of the following

GENERAL WELL-BEING:	**BREAST:**	❑ **EARS, NOSE, THROAT, MOUTH:**
❑ Weight Loss	❑ Pain	❑ Ulcers
❑ Weight Gain	❑ Nipple Discharge	❑ Sinus problems
❑ Fever	❑ Breast Lump	❑ Hearing Problems
❑ Fatigue	❑ Rash	❑ Ringing in the Ears
❑ Excessive Thirst		❑ Difficulty Swallowing
❑ Excessive Hunger	**CARDIOVASCULAR:**	
❑ Problems Sleeping	❑ Shortness of Breath	**EYES:**
❑ Heat Intolerance	❑ Chest Pain	❑ Vision Changes
❑ Cold Intolerance	❑ Palpitations	❑ Contacts/Glasses
	❑ Swelling	❑ Excessive Tearing / Eye Discharge
BLOOD SYSTEM:	**RESPIRATORY:**	**MUSCULOSKELETAL:**
❑ Bleed Easily	❑ Coughing	❑ Weakness
❑ Bruise Easily	❑ Coughing up Blood	❑ Muscle Pain
❑ Enlarged Lymph Nodes	❑ Wheezing	
❑	❑	
❑	❑	
❑	❑	
❑	❑	
❑	❑	

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REVIEW OF SYSTEMS (Continued)		
GASTROINTESTINAL:	**NEUROLOGICAL:**	**URINARY/GYNECOLOGIC:**
❑ Diarrhea	❑ Dizziness	❑ Blood in Urine
❑ Constipation	❑ Headache	❑ Painful Urination
❑ Nausea/Vomiting	❑ Near Passing Out	❑ Urgency or Frequency
❑ Bloody Stools	❑ Numbness	
❑ Pain with bowel movement	❑ Difficulty walking	Women: ❑ Irregular Periods
❑ Abdominal Pain	❑ Memory Problems	❑ Vaginal Discharge
PSYCHOLOGICAL:	**SKIN:**	**SLEEP DISTURBANCE:**
❑ Depression	❑ Acne	❑ Difficulty Falling Asleep
❑ Severe Mood Swings	❑ Hair Loss	❑ Waking up Frequently at night
❑ Anxiety	❑ Excessive Hair Growth	❑ Excessive Daytime Sleepiness
❑ Confusion	❑ Dryness	
❑ Severe Agitation	❑ Rash	

SOCIAL HISTORY

Are you currently married or with a partner? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No ❑ Quit

If yes: How many cigarettes a day? ___________ For how long? ___________

If quit: When did you quit? ___________

When you did smoke, how many cigarettes a day? ___________ For how long? ___________

Do you Exercise? ❑ Yes ❑ No

If yes: Aerobic activity? ❑ Yes ❑ No Times per week?: ___________

Strength training? ❑ Yes ❑ No Times per week?: ___________

Yoga/Stretching? ❑ Yes ❑ No Times per week?: ___________

Do you drink alcohol? ❑ No ❑ Yes, _______ drinks per ❑ Day ❑ Week ❑ Month

Do you consume Caffeine? ❑ No ❑ Yes, _______ drinks per ❑ Day ❑ Week ❑ Month

Do you currently use recreational drugs? ❑ Yes ❑ No

Have you used recreational drugs in the past? ❑ Yes ❑ No

Are you currently employed? ❑ Yes ❑ No

If yes: Type of work:____

MIDTOWN
ENDOCRINE ASSOCIATES

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IS THERE ANYTHING SPECIFIC YOU WISH TO DISCUSS WITH YOUR PHYSICIAN THIS VISIT?

IF YOU HAVE DIABETES complete the following questions:

At what age was diabetes diagnosed? ___________

Have you seen a diabetes educator? ❑ Yes ❑ No

Have you seen a nutritionist in regards to diabetes? ❑ Yes ❑ No

What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Diabetes in Pregnancy ❑ Unknown

Do you check your blood sugars at home? ❑ Yes ❑ No

If yes, What is a high reading for you? ___________

- What is a low reading for you? ___________
- Do your sugars ever go below 70? ❑ Yes ❑ No

  If yes, is this ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely
- Are you aware of when your sugar is low? ❑ Yes ❑ No
- Have you been hospitalized for low blood sugars? ❑ Yes ❑ No

  If yes, when _______________________ and where _______________________

Do you know what an A1c is? ❑ Yes ❑ No

Do you know your A1c? ❑ Yes ❑ No If yes what is it? _____________

Have you ever been hospitalized for high blood sugars? ❑ Yes ❑ No

If yes, when_______________________ and where _______________________

Do you have diabetes related eye problems? ❑ Yes ❑ No Eye Doctor: _______________

When was your last eye exam? _______________ ❑ Never

Do you have foot problems? ❑ Yes ❑ No Foot Doctor: _______________

When did you last give a urine sample for your diabetes? _______________ ❑ Never

Do you have diabetes related kidney problems? ❑ Yes ❑ No

When did you last have a cardiac assessment? _______________________ ❑ Never

Do you have heart disease? ❑ Yes ❑ No

Males: Do you have erectile dysfunction? ❑ Yes ❑ No

Do you have any specific issues you would like to address with your physician regarding your diabetes?

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IF YOU ARE BEING SEEN FOR THYROID CANCER, complete the following questions:
At what age was your thyroid cancer diagnosed? Age: ____________
Did you have surgery for your thyroid cancer? ❑ Yes ❑ No
If yes, list surgery location: ____________
Did you have radioactive iodine? ❑ Yes ❑ No
If yes, do you recall the dose? Dose: ____________
Do you have a history of low calcium? ❑ Yes ❑ No
If yes, what medication are you taking for it? Medication: ____________
When was your last neck ultrasound performed?
Date: ____________ Location: ____________ ❑ Not applicable
When was your last whole body scan performed?
Date: ____________ Location: ____________ ❑ Not applicable
Do you know your most recent TSH and Thyroglobulin level? ❑ Yes ❑ No
TSH: ____________ Thyroglobulin level: ____________ Date: ____________

IF YOU ARE BEING SEEN FOR OSTEOPOROSIS, complete the following questions:		
Please Check Yes or No if any of the following apply to you:		
	Yes	No
Have you ever been treated for osteoporosis? If yes, with what medications? ____________ From what dates: ________ to ________		
Is there a family history of osteoporosis and/or hip fracture? If yes, list family member ____________		
Do you have a history of hip or spine fracture? If yes, list location ____________ age ________		
Do you have a history of any other bone fractures? If yes, list location ____________ age ______		
Are you lactose-intolerant?		
Do you have celiac disease/gluten intolerance?		
Have you ever been diagnosed with a thyroid disorder?		
Have you ever been diagnosed with a calcium disorder?		
Do you have a history of kidney stones?		
Do you have a history of anorexia?		
When was your last bone density test? ❑ N/A Date: ____________ Location: ____________		
Do you take Calcium or Vitamin D? ❑ Yes ❑ No		
If yes, Calcium dose: ____________ Vitamin D dose: ____________		
For Females,		
Date of last period ____________		
Are you in menopause? ❑ Yes ❑ No		
If yes, were you treated with Hormone replacement therapy? ❑ Yes ❑ No		
Indicate from what dates – from ____________ to ____________		

PATIENT SIGNATURE					DATE
PROVIDER SIGNATURE					DATE