General Endocrinology Questionnaire

Patient Name: _____ Date of Birth: _____

Self-referral or referred by: _____ Reason for referral: _____

Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

Name of Medications/ Supplements/ Vitamins	Dose	Frequency

1) What is your pharmacy name, address and number?

_____

_____

2) What medical problems do you have?

Medical Problem	Year of diagnosis
(For ex. High blood pressure)	(For ex. 2005)

3) Do you have any of these medical problems specifically?

Medical history	Yes	No	Year of diagnosis and further details
Diabetes mellitus			
Thyroid disease			
Parathyroid disease			
Pituitary disease			
Adrenal disease			
Osteoporosis/Bone disease			

4) Do you have medication allergies? Yes or No

Medication Allergies	Reaction

5) Have you had any prior surgeries? Yes or No

Previous Surgeries	Month and year

6) Have you been hospitalized before? Yes or No

Hospitalization reason	Month and year

7) Does anyone in your family have a history of the conditions below?

Family History	Yes	No	Details
Diabetes mellitus			
Thyroid disease			
Parathyroid disease			
Pituitary disease			
Adrenal disease			
Osteoporosis/Bone disease			

8) Please answer these questions as it pertains to you

Social history	Yes	No	Details
Do you exercise regularly?			_____ minutes per day _____ days per week
Do you (or did) you smoke?			___ packs per day for ___ years. Quit date ____
Do you drink alcohol?			_____ drinks per day / week