Pituitary Questionnaire

Patient Name: _____ Date of Birth: _____

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

Prior endocrinologist (if any): _____

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

1) When were you told about your pituitary problem? _____
2) How was it found? _____
3) When was the last brain MRI you had (Please bring a CD with images and the report with you)?

   _____
4) What treatments have you been on related to this? _____

   _____
5) Have you had pituitary surgery? Yes ____ or No____. If yes, when and where was it done?

   _____
6) Have you had radiation treatment to the head or neck? Yes ____ or No____. If yes, when?

   _____
7) Are you having any symptoms associated with your pituitary problem? Yes ____ or No____. If yes, explain:

   _____
8) Are you taking or have you taken any of these medicines in the last 2 months?

Medications	Yes	No	Name of medication
For depression	___	___	_____
For bipolar disorder or schizophrenia	___	___	_____
Reglan	___	___	_____
Pepcid or Zantac	___	___	_____
Verapamil or methyldopa	___	___	_____
Hormones (Testosterone, estrogen, etc)	___	___	_____
Steroids (Inhaled, oral, nasal, injectable or topical)	___	___	_____
Opioids (morphine, methadone, etc)	___	___	_____
Herbal medications	___	___	_____

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

Medical History	Yes	No	Year or diagnosis and details
Thyroid disease	___	___	_____
Parathyroid disease	___	___	_____
Diabetes mellitus	___	___	_____
Adrenal disease	___	___	_____
Osteoporosis/bone disease	___	___	_____
Liver disease	___	___	_____
Renal disease	___	___	_____
Seizures	___	___	_____
Pancreatic or gastrointestinal tumors	___	___	_____

10) Does anyone in your family have a history of pituitary problems, parathyroid problems or pancreatic/gastrointestinal tumors? Yes ____ or No____. If yes, please describe:
_____

11) Have you used amphetamines or cannabis in the last 1 month? ___Yes or ____No

Symptom Review (Check if you have had any in the last 1 month):

Fatigue ____ fever____ weight gain ____ weight loss ____

Headaches ____ brain fog ____ changes in features of your face____

Vision changes ____ Bumping into things____

Dry skin ____ itchy skin ____ stretch marks on abdomen____ easy bruising____

Chest pain____ shortness of breath ____ leg swelling ____ palpitations ____

Abdominal pain____ Nausea ____ vomiting ____ diarrhea ____ constipation ____

For women: Irregular periods____ milky breast discharge ____ low sex drive____

For men: Erectile dysfunction____ milky breast discharge ____ or low sex drive____

Anxiety ____ depression ____

Intolerance to cold ____ intolerance to heat____ hair loss ____

Hand tremor ____ or shaking____

Weakness of arms or legs ____ joint pain ____ increase in ring or shoe size____

None of the above____