Thyroid/Endocrine Disorders Initial Evaluation Form

Please fill this questionnaire out. If you have problems answering these questions, leave a question mark.
This is a confidential record.

I. PERSONAL INFORMATION

Legal Name ______ **First** ______ **MI** ______ **Last** ______

Date Of Birth ______ **Current Age** ______ **MALE FEMALE** **Circle One**

Birthplace ______ **Marital Status** ______

Referring Physician ______ **Address** ______ **Phone** ______

Family Physician ______ **Address** ______ **Phone** ______

Gynecologist ______ **Address** ______ **Phone** ______

Other Physicians ______ **Address** ______ **Phone** ______

Other Physicians ______ **Address** ______ **Phone** ______

Current Occupation: ____________________ **Past Occupation:** ____________________

Highest grade completed: (please check only one)

Some Grade School____ Some High School____ Some College____ Some Postgraduate____
Grade School____ High School____ College Graduate____ Postgraduate Degree____

Tobacco use: Yes____ No____ Year started_________ Year stopped_________

Cigarettes _____ Cigars _____ Chewing tobacco _____ Amount per day_________

Vaping (E-Cigarette): Yes____ No____ Year started_________ Year stopped_________

Alcohol use: Yes____ No____ Type of beverage__________________________ Amount_______________

Recreational drug use: Current____ Past____ Never____ Type ____

Revised 04/2016

II. FAMILY HISTORY

	AGE		(If Living) HEALTH	AGE at DEATH		(If Deceased) CAUSE of DEATH
Father	/	/		/	/	
Mother	/	/		/	/	
Brothers/Sisters	/	/		/	/	
	/	/		/	/	
Spouse	/	/		/	/	
Sons/Daughters	/	/		/	/	

DO YOU KNOW OF ANY BLOOD RELATIVE WHO HAS OR HAD (Circe and give Relationship)

Stroke ______________________ **Calcium Problems** ______________________

High Blood Pressure ______________________ **Adrenal Problems** ______________________

Heart Attack ______________________ **Kidney Disease** ______________________

Diabetes ______________________ **Pituitary Problems** ______________________

Osteoporosis/Bone Disease ______________________ **Thyroid Problems** ______________________

Cancer ______________________ **What Type** ______________________

Arthritis ______________________ **What Type** ______________________

III. PAST HISTORY

Past surgeries or significant injuries

Surgeries or injuries	Date:	Surgeries or injuries	Date:

IV. ALLERGIES

NAME ANY DRUG YOU ARE ALLERGIC TO

Name of Drug & Reaction ______________________

____

____

DESCRIBE ANY OTHER ALLERGIES YOU HAVE ______________________

____

____

V. YOUR MEDICAL HISTORY

Head/Ears/Eyes/Nose/Throat

Eye exam **Yes No**
When: Date: ____/____/______
Dental Exam **Yes No**
When: Date: ____/____/______
Past eye surgery **Yes No**
(including laser treatments)
Sinus problems **Yes No**

Cardiovascular

High blood pressure **Yes No**
Heart murmurs **Yes No**
Valvular disease **Yes No**
Heart attack **Yes No**
Blocked arteries **Yes No**
High cholesterol **Yes No**
Congestive heart failure **Yes No**
Past cardiac stress test **Yes No**
Past EKG **Yes No**

Respiratory

Pneumonia **Yes No**
Asthma **Yes No**
COPD/Emphysema **Yes No**

Skin

Past skin ulcers **Yes No**
Psoriasis **Yes No**
Other skin disease **Yes No**
Type________________________

Genitourinary

Dialysis Yes **No**
Kidney disease **Yes No**
Yeast infection **Yes No**
Protein in urine **Yes No**

Endocrine

Diabetes **Yes No**
Thyroid problems **Yes No**

Gastrointestinal

History of peptic ulcers **Yes No**
Crohns/colitis **Yes No**
Hepatitis/liver problems **Yes No**
Gallstones **Yes No**
Irritable bowel syndrome **Yes No**
Reflux/Gerd **Yes No**
Hiatal hernia **Yes No**

General

Cancer Yes No
Type_________________________

Pregnancy/Menstrual History

Endometriosis **Yes No**
Ovarian cysts Yes **No**
Are your periods regular **Yes No**
Presently sexually active **Yes No**
Birth Control method_______________
Last menstrual period date___________
Number of pregnancies_____________
Number of children______________

Neurological

Seizures **Yes No**
Stroke **Yes No**
Head Trauma **Yes No**
Neuropathy **Yes No**

Musculoskeletal

Osteoporosis **Yes No**
Arthritis **Yes No**

Hematological/Lymphatic

Anemia **Yes No**
Past blood transfusion **Yes No**

Psychosocial

Anxiety Yes **No**
Depression **Yes No**
Mental Health **Yes No**
Drug/alcohol abuse **Yes No**
Stress (at home/work) **Yes No**
Abuse **Yes No**
(physical/emotional/sexual)

Other Current or past health issues

____
____
____
____

VI. YOUR Current Symptoms

Head/Ears/Eyes/Nose/Throat

Vision problem **Yes No**
Sores in mouth **Yes No**
Sore throat/hoarseness **Yes No**
Ringing in ears **Yes No**

Cardiovascular

Rapid or irregular heartbeat **Yes No**
Abnormal swelling legs/feet **Yes No**
Chest pain or pressure **Yes No**

Respiratory

Shortness of breath **Yes No**
Cough **Yes No**
Coughing up sputum/blood **Yes No**

Skin

Skin rashes/itching **Yes No**
Dry skin **Yes No**
Acne **Yes No**
Hair Loss **Yes No**

Genitourinary

Frequent urination **Yes No**
Pain with urination **Yes No**
Blood in urine **Yes No**
Do you get up at night
to urinate **Yes No**
(if so how often)________
Erectile dysfunction **Yes No**

Gastrointestinal

Constipation **Yes No**
Diarrhea **Yes No**
Nausea/vomiting **Yes No**
Heartburn/indigestion **Yes No**
Blood in stool **Yes No**
Abdominal pain **Yes No**

Neurological

Tingling **Yes No**
Pain or cramps **Yes No**
Burning pain **Yes No**
Frequent headaches **Yes No**

Musculoskeletal

Pain/stiffness in joints **Yes No**
Backaches **Yes No**

Hematological/Lymphatic

Enlarged glands **Yes No**
Excessive bruising **Yes No**
Abnormal bleeding **Yes No**

General

Fatigue **Yes No**
Frequent thirst **Yes No**
Change in appetite **Yes No**
Trouble sleeping **Yes No**
Weight loss (past year) **Yes No**
How much ____________
Weight gain (past year) **Yes No**
How much ____________
Heat Intolerance **Yes No**
Cold Intolerance **Yes No**
Excess Sweating **Yes No**

VII. MEDICATIONS

List the current Medications you are taking the doses and frequency (or provide a list)

Name of Medication	Dose of Medication

DESCRIBE BRIEFLY YOUR PRESENT SYMPTOMS____

____

____

____

Physicians Use Only: