Medical Questionnaire

Please complete this prior to your appointment and bring the completed form to your appointment. Thank you.

GENERAL INFORMATION:

Name: ____

Date of Birth: _____/_____/_____

REFERRING PROVIDER:

NAME	ADDRESS	PHONE NUMBER

Reason for visit:

- ❑ Adrenal issues
- ❑ Diabetes in Pregnancy
- ❑ Osteoporosis
- ❑ Thyroid cancer
- ❑ Diabetes Type 1
- ❑ Hyperthyroidism
- ❑ PCOS
- ❑ Weight management
- ❑ Diabetes Type 2
- ❑ Hypothyroidism
- ❑ Prediabetes / diabetes prevention
- ❑ Insulin pump management/CGM

Other: ______________________________

ARE YOU WILLING TO PARTICIPATE IN POSSIBLE FUTURE RESEARCH ACTIVITIES?

❑ Yes, I would like to be contacted in the future to discuss potential research projects.
❑ No, I do not want to be contacted in the future for potential research projects.

ALLERGIES: ❑ No Known Allergies

MEDICINE	REACTION

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

Surgery	Date	Location

Magnolia
ENDOCRINOLOGY

Medical Questionnaire Cont.

MEDICATIONS

Name of Medications	Dosage	Date Started
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

MEDICAL HISTORY Check if you now 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

Females:

- ❑ Polycystic Ovary Syndrome
- ❑ Unwanted facial or body hair

Other:____________________

____

____

Medical Questionnaire Cont.

FAMILY HISTORY - Are you adopted? ❑ Yes ❑ No

Have any of your family members ever had any of the following?

	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:

❑ Weight Loss
❑ Weight Gain
❑ Fever
❑ Fatigue
❑ Excessive Thirst
❑ Excessive Hunger
❑ Problems Sleeping
❑ Heat Intolerance
❑ Cold Intolerance

GASTROINTESTIONAL:

❑ Diarrhea
❑ Constipation
❑ Nausea / Vomiting
❑ Bloody Stools
❑ Pain with BM's
❑ Abdominal Pain
❑ Excessive bloating / Gas

BREAST:

❑ Pain
❑ Nipple Discharge
❑ Breast Lump
❑ Rash

CARDIOVASCULAR:

❑ Shortness of Breath
❑ Chest Pain
❑ Palpitations
❑ Swelling

PSYCHOLOGICAL:

❑ Depression
❑ Severe Mood Swings
❑ Anxiety
❑ Confusion
❑ Severe Agitation

SKIN:

❑ Acne
❑ Hair Loss/Growth
❑ Dryness
❑ Rash

ENT:

❑ Ulcers
❑ Sinus Problems
❑ Hearing Problems
❑ Ringing in the Ears
❑ Difficulty Swallowing

BLOOD SYSTEM:

❑ Bleed Easily
❑ Bruise Easily
❑ Enlarged Lymph Nodes

NEUROLOGICAL:

❑ Dizziness
❑ Headache
❑ Near passing out
❑ Numbness
❑ Difficulty Walking
❑ Memory Problems

EYES:

❑ Vision Changes
❑ Loss of Peripheral Vision
❑ Excessive Tearing

MUSCULOSKELETAL:

❑ Weakness
❑ Muscle Pain

RESPIRATORY:

❑ Coughing
❑ Coughing up Blood
❑ Wheezing

URINARY / GYNECOLOGIC:

❑ Blood in Urine
❑ Painful Urination
❑ Urgency or Frequency
❑ Pain with Intercourse

Women:

❑ Irregular Periods
❑ Vaginal Discharge

Medical Questionnaire Cont.

SOCIAL HISTORY:

Marital Status ❑ Married ❑Single ❑Divorced ❑Separated Children? How many? ________________

Do you smoke? ❑ Yes ❑ No Quit, date: ____________

If yes: How many cigs a day? ________________ for how long? ____________________

If quit: When did you quit? ___________________

When you did smoke, how many cigarettes per day? _____________ for how long? ___________

Do you exercise? What is your routine? ____

Do you consume alcohol? How frequently? ____

Do you currently use recreational drugs? __________________________ Have you used them in the past? _____

Employment status: __________________ Place of employment _____________________________________

Thank you for choosing us to serve you!

The Magnolia Endocrinology Team