ENDOCRINOLOGY CONSULTANTS
OF EAST TENNESSEE
*Balanced Care. Better Life.*

Name: _____ Date of Birth: ___ /___ /_____ Today's Date: ___ /___ /_____

# New Patient Health Questionnaire

*** Please complete this form and bring it with you to your appointment. ***

Reason you were referred to our office: _____

Main health concerns for today's visit: _____

_____

**Past Medical History** (List all diagnosed conditions or diseases)

_____

_____

_____

_____

_____

**Past Surgical History** (List all surgeries and approximate dates)

| Surgery | Approximate Date |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Social History**

Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated

Highest Education Level: ☐ grade school ☐ high school ☐ college ☐ graduate school

Occupation: _____

Smoking Status: ☐ never ☐ former (quit date: ___ /___ /_____) ☐ current every day

Current Smokers: Type: ☐ cigarettes ☐ cigar ☐ vapor ☐ smokeless tobacco

Number of cigarettes/cigars per day: _____

Alcohol: ☐ never ☐ occasional ☐ daily number of drinks per week: _____

Illegal Drugs: ☐ never ☐ occasional ☐ daily

Name: _____ Date of Birth: ___ /___ /_____

**Family History** (List major health problems, diabetes, cancer, heart disease, thyroid disorder etc.)

☐ Family History Unknown

| Family Member | Living / Deceased | Age of Death | Cause of Death / Health Problems |
|---|---|---|---|
| Mother | ☐ Living ☐ Deceased | | ☐ None |
| Father | ☐ Living ☐ Deceased | | ☐ None |
| (Circle appropriate family member below) | | | |
| Sister Brother Child | ☐ Living ☐ Deceased | | ☐ None |
| Sister Brother Child | ☐ Living ☐ Deceased | | ☐ None |
| Sister Brother Child | ☐ Living ☐ Deceased | | ☐ None |
| Sister Brother Child | ☐ Living ☐ Deceased | | ☐ None |
| Sister Brother Child | ☐ Living ☐ Deceased | | ☐ None |

**Medication Allergies (List all medication allergies, including reaction)**

☐ No known drug allergies

| Name of Medication | Type of Reaction (rash, shortness of breath) |
|---|---|
| | |
| | |
| | |
| | |

**Medication List (List all current medications, including supplements and over the counter)**

☐ Not currently taking any medications

| Name of Medication | Dose | Instructions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Name: _____ Date of Birth: ___ /___ /_____

**Medication List Cont'd**

| Name of Medication | Dose | Instructions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Name: _____ Date of Birth: ___ /___ /_____ Today's Date: ___ /___ /_____

## Review of Systems

| General | Yes | No |
|---|---|---|
| weight loss | ☐ | ☐ |
| weight gain | ☐ | ☐ |
| loss of appetite | ☐ | ☐ |
| fever/chills | ☐ | ☐ |
| sweating | ☐ | ☐ |
| weakness/fatigue | ☐ | ☐ |
| difficulty sleeping | ☐ | ☐ |

**Comments:**

| Eyes | Yes | No |
|---|---|---|
| eye irritation | ☐ | ☐ |
| eye discharge | ☐ | ☐ |
| eye pain | ☐ | ☐ |
| light sensitivity | ☐ | ☐ |
| loss of vision | ☐ | ☐ |
| blurred vision | ☐ | ☐ |
| double vision | ☐ | ☐ |

**Comments:**

| Ear, Nose, Throat / Neck | Yes | No |
|---|---|---|
| ear pain | ☐ | ☐ |
| ear discharge | ☐ | ☐ |
| loss of hearing | ☐ | ☐ |
| ringing in ears | ☐ | ☐ |
| nasal congestion | ☐ | ☐ |
| nasal discharge | ☐ | ☐ |
| sinus pain | ☐ | ☐ |
| nosebleeds | ☐ | ☐ |
| hoarseness | ☐ | ☐ |
| sore throat | ☐ | ☐ |
| difficulty swallowing | ☐ | ☐ |
| neck pain | ☐ | ☐ |
| neck swelling | ☐ | ☐ |

**Comments:**

| Cardiovascular | Yes | No |
|---|---|---|
| high blood pressure | ☐ | ☐ |
| low blood pressure | ☐ | ☐ |
| rapid heart rate | ☐ | ☐ |

| Cardiovascular Cont'd | Yes | No |
|---|---|---|
| irregular heart rate | ☐ | ☐ |
| chest discomfort/pain | ☐ | ☐ |
| shortness of breath | ☐ | ☐ |
| fainting | ☐ | ☐ |
| swelling of hands/feet | ☐ | ☐ |
| leg cramps | ☐ | ☐ |

**Comments:**

| Respiratory | Yes | No |
|---|---|---|
| cough | ☐ | ☐ |
| coughing up blood | ☐ | ☐ |
| shortness of breath | ☐ | ☐ |
| wheezing | ☐ | ☐ |

**Comments:**

| Gastrointestinal | Yes | No |
|---|---|---|
| abdominal pain | ☐ | ☐ |
| abdominal bloating | ☐ | ☐ |
| loss of appetite | ☐ | ☐ |
| indigestion | ☐ | ☐ |
| gas | ☐ | ☐ |
| nausea | ☐ | ☐ |
| vomiting | ☐ | ☐ |
| constipation | ☐ | ☐ |
| hemorrhoids | ☐ | ☐ |
| diarrhea | ☐ | ☐ |
| blood in stool | ☐ | ☐ |

**Comments:**

| Genitourinary | Yes | No |
|---|---|---|
| frequent urination | ☐ | ☐ |
| pain/burning with urination | ☐ | ☐ |
| urgent urination | ☐ | ☐ |
| urinary incontinence | ☐ | ☐ |
| nighttime urination | ☐ | ☐ |
| difficulty starting urine flow | ☐ | ☐ |
| blood in urine | ☐ | ☐ |
| heavy menstrual periods | ☐ | ☐ |
| painful menstrual periods | ☐ | ☐ |

Name: _____ Date of Birth: ___ /___ /_____

| Genitourinary Cont'd | Yes | No |
|---|---|---|
| irregular menstrual periods | ☐ | ☐ |
| pelvic pain | ☐ | ☐ |
| lack of sex drive | ☐ | ☐ |
| erectile dysfunction | ☐ | ☐ |

**Comments:**

| Muscles / Joints | Yes | No |
|---|---|---|
| muscle or joint stiffness | ☐ | ☐ |
| muscle or joint pain | ☐ | ☐ |
| muscle or joint swelling | ☐ | ☐ |
| muscle weakness | ☐ | ☐ |
| muscle cramps | ☐ | ☐ |
| back pain | ☐ | ☐ |
| knee pain | ☐ | ☐ |
| hip pain | ☐ | ☐ |

**Comments:**

| Skin / Hair / Nails | Yes | No |
|---|---|---|
| rash | ☐ | ☐ |
| itching | ☐ | ☐ |
| dryness | ☐ | ☐ |
| lesions | ☐ | ☐ |
| wounds slow to heal | ☐ | ☐ |
| change in nails | ☐ | ☐ |
| change in skin color | ☐ | ☐ |
| hair loss | ☐ | ☐ |
| excessive hair growth | ☐ | ☐ |
| acne | ☐ | ☐ |
| flushing | ☐ | ☐ |
| excessive sweating | ☐ | ☐ |

**Comments:**

| Neurologic | Yes | No |
|---|---|---|
| weakness | ☐ | ☐ |
| dizziness | ☐ | ☐ |
| seizures | ☐ | ☐ |
| headaches | ☐ | ☐ |
| pain/numbness hands/feet | ☐ | ☐ |
| tremors | ☐ | ☐ |
| loss of consciousness | ☐ | ☐ |
| memory loss | ☐ | ☐ |
| personality changes | ☐ | ☐ |

| Neurologic Cont'd | Yes | No |
|---|---|---|
| difficulty with concentration | ☐ | ☐ |
| difficulty with speaking | ☐ | ☐ |
| poor balance | ☐ | ☐ |

**Comments:**

| Mental Health | Yes | No |
|---|---|---|
| anxiety | ☐ | ☐ |
| depression | ☐ | ☐ |
| hallucinations | ☐ | ☐ |
| suicidal thoughts | ☐ | ☐ |
| alcohol/substance abuse | ☐ | ☐ |
| confusion | ☐ | ☐ |

**Comments:**

| Endocrine | Yes | No |
|---|---|---|
| high blood sugar | ☐ | ☐ |
| low blood sugar | ☐ | ☐ |
| excessive hunger | ☐ | ☐ |
| excessive thirst | ☐ | ☐ |
| cold intolerance | ☐ | ☐ |
| heat intolerance | ☐ | ☐ |
| change in hat or ring size | ☐ | ☐ |
| loss of height | ☐ | ☐ |
| bone fractures | ☐ | ☐ |

**Comments:**

| Blood / Lymphatic | Yes | No |
|---|---|---|
| nosebleeds | ☐ | ☐ |
| bleeding gums | ☐ | ☐ |
| bruising | ☐ | ☐ |
| swollen lymph nodes | ☐ | ☐ |
| painful lymph nodes | ☐ | ☐ |
| recurrent infections | ☐ | ☐ |

**Comments:**

| Allergies / Immunologic | Yes | No |
|---|---|---|
| hives | ☐ | ☐ |
| seasonal allergies | ☐ | ☐ |
| HIV exposure | ☐ | ☐ |

**Comments:**