Pinehurst Medical Clinic

Division of
EndocrinologyHealth
Questionnaire

In order to make your first visit more personal yet comprehensive, please assist our Endocrinologist in gathering the necessary information to aid in your health treatment plan. Filling this out thoroughly ahead of time will limit delays in the waiting room.

NAME: AGE:

DATE: DATE OF BIRTH:

What is the purpose of this visit?

What medical conditions do you have?

Are you currently being treated by another physician?

What surgeries have you had? (Include Approximate Dates).

What prescription medications are you taking? Please bring in bottles or provide a list below.

What over-the-counter medicines, vitamins, and other products do you use for your health?

Please list any allergic reactions you have to any medications.

Family History

Have any of your close relatives had (Circle all that apply):

Diabetes	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
High blood pressure	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Heart attacks	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Colon cancer	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Breast cancer	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Strokes	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Osteoporosis	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Allergies	☐ Yes	☐ No	Mother / Father / Brother / Sister / Son / Daughter
Thyroid Disorders	☐ Yes	☐ No	*List **Any** Relative_____
Thyroid Cancer	☐ Yes	☐ No	*List **Any** Relative_____

What other medical problems, if any, run in your family?

Social History

Are you married, single, divorced, widowed?

Do you work, retired, disabled?

List any particular hobbies.

Habits

Do you smoke cigarettes? ☐ Yes ☐ No

If yes, how many packs a day?_____How many years? _____

If quit, when? _____

Do you use alcohol? ☐ Yes ☐ No

If yes, how many drinks per week?_____What time of day? _____

What type of alcohol? _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, describe.

What type of diet do you maintain?

Disease Prevention

Indicate if you have had the following and when:

Tetanus vaccine	☐ Yes	☐ No	Date: _____
Pneumonia vaccine	☐ Yes	☐ No	Date: _____
Flu vaccine	☐ Yes	☐ No	Date: _____
Hepatitis B vaccine	☐ Yes	☐ No	Date: _____
Shingles vaccine	☐ Yes	☐ No	Date: _____

Systems Review

HEENT

Poor Vision	☐ Yes	☐ No
Recurrent dizziness or Light headedness	☐ Yes	☐ No
Poor hearing	☐ Yes	☐ No
Ringing of ears	☐ Yes	☐ No
Chronic hoarseness (lasting several weeks)	☐ Yes	☐ No
Previous radiation treatment to your head, neck, or chest	☐ Yes	☐ No

Respiratory/Cardiovascular

Chest Pain	☐ Yes	☐ No
Palpitations or irregular heart beat	☐ Yes	☐ No
Difficulty breathing while active	☐ Yes	☐ No
Difficulty breathing while resting	☐ Yes	☐ No
Leg pain while resting or with exercise	☐ Yes	☐ No
Swelling in the legs or feet	☐ Yes	☐ No

Gastrointestinal

Poor appetite	☐ Yes	☐ No
Excessive appetite	☐ Yes	☐ No
Frequent indigestion	☐ Yes	☐ No
Frequent nausea or vomiting	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Pain in the abdomen	☐ Yes	☐ No
Regurgitation of food or acid after eating big meals	☐ Yes	☐ No
Vomiting blood	☐ Yes	☐ No
Frequent stools	☐ Yes	☐ No
Chronic constipation	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No

GU

Blood in urine	☐ Yes	☐ No
Frequent, painful or difficulty urinating	☐ Yes	☐ No
Inability to control urine	☐ Yes	☐ No
For men:		
Erectile dysfunction?	☐ Yes	☐ No
For women:		
Irregular menses?	☐ Yes	☐ No
Date of menopause?	_____	

Musculoskeletal

Painful or swollen joints	☐ Yes	☐ No
History of back problems	☐ Yes	☐ No
Difficulty with pain or weakness in your muscles	☐ Yes	☐ No

Lymphatic

Swollen glands	☐ Yes	☐ No
Chronic infections	☐ Yes	☐ No

Hematologic

Anemia	☐ Yes	☐ No
Blood disorders	☐ Yes	☐ No

General

Dizzy or fainting spells	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No
Chronically tired or no energy	☐ Yes	☐ No
Spells of depression	☐ Yes	☐ No
Difficulty sleeping	☐ Yes	☐ No
Crying spells	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Changes in Weight	☐ Yes	☐ No

Thank you for completing this. We look forward to seeing you!