LiveNew Colorado Endocrinology

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In order to care for you, we ask that you answer the following questionnaire as completely as possible.

Patient's Personal Contact Information

Name: _____ Age: _____ Date of Birth: ____/____/_____

Gender: ☐ F ☐ M Social Security Number: _____

Address: _____ City:_____ State:_____ Zip Code:_____

Home Phone (____) _____-_____; Cell Phone (____) _____-_____; Work Phone (___) ____- _____

Email: _____

Insurance Carrier: _____Subscriber Name_____

Relationship to self**:**_____ Social Security #**:** _____ DOB**:**_____

Emergency Contact:_____ Relationship**:** _____

Address**:** _____ Phone #: _____

Pharmacy:	Address/Cross Streets	Phone Number	Preferred
Local :_____	_____	_____	☐
Mail Order:_____	_____	_____	☐

Other Healthcare Providers:

Primary Care: _____Contact #:_____ Fax #_____

Specialist: _____Contact #:_____ Fax #_____

Reason for Consultation: _____

Medication Allergies:_____

Check if you are allergic to ☐ IV Contrast Dye

Current Medications with dosage and frequency:

1._____ **9.** _____

2._____ **10.** _____

3._____ **11.**_____

4._____ **12.** _____

5._____ **13.** _____

6._____ **14.** _____

7._____ **15.**_____

8._____ **16.**_____

Patient Name: _____ Date: _____

Review of Systems: In the last 2 weeks, have you experienced any of the following symptoms? Respond to each.

Constitutional

Weight Loss (unintentional)	☐Yes	☐No
Weight Gain (unintentional)	☐Yes	☐No
Appetite Changes (↑ or ↓)	☐Yes	☐No
Fatigue (profound)	☐Yes	☐No
Fever	☐Yes	☐No
Night sweats	☐Yes	☐No
Irritability	☐Yes	☐No

Eyes

Do you wear glasses or contacts (circle one if yes)	☐Yes	☐No
Dry eyes	☐Yes	☐No
Eye pain or drainage	☐Yes	☐No
Visual Changes	☐Yes	☐No

ENT/Mouth

Ear pain or drainage	☐Yes	☐No
Frequent sinus infections	☐Yes	☐No
Hearing Changes or loss	☐Yes	☐No

Cardiovascular

Chest pain or heaviness	☐Yes	☐No
Palpitations or rapid heart beat	☐Yes	☐No
Exertional shortness of breath	☐Yes	☐No
Shortness of breath when lying flat in bed	☐Yes	☐No
Swelling of feet or legs	☐Yes	☐No

Respiratory

Blood in your sputum	☐Yes	☐No
Coughing (lasting > 3 months)	☐Yes	☐No
Shortness of breath	☐Yes	☐No
Wheezing	☐Yes	☐No

Gastrointestinal

Heartburn or Indigestion	☐Yes	☐No
Vomiting or nausea	☐Yes	☐No
Swallowing difficulty	☐Yes	☐No
Abdominal pain	☐Yes	☐No
Blood in your stool	☐Yes	☐No
Constipation	☐Yes	☐No
Diarrhea or frequent bowel movements	☐Yes	☐No

Genitourinary

Blood in your urine	☐Yes	☐No
Urinary Retention	☐Yes	☐No
Incontinence	☐Yes	☐No
Erection problems	☐Yes	☐No
Irregular menstrual cycles	☐Yes	☐No
Vaginal discharge or bleeding	☐Yes	☐No

Musculoskeletal

Broken bones	☐Yes	☐No
Joint pain or swelling	☐Yes	☐No
Muscle aches	☐Yes	☐No
Muscle weakness	☐Yes	☐No

Breasts

Masses or lumps	☐Yes	☐No
Nipple discharge	☐Yes	☐No

Neurologic

Seizures	☐Yes	☐No
Headaches	☐Yes	☐No
Slurred speech	☐Yes	☐No
Pain or burning in legs or feet	☐Yes	☐No
Numbness or tickling in legs or feet	☐Yes	☐No

Psych

Anxiety without clear explanation	☐Yes	☐No
Sadness lasting for days or weeks	☐Yes	☐No
Sleep disturbance	☐Yes	☐No

Diabetes/Endocrine

Increased thirst	☐Yes	☐No
Increased urination	☐Yes	☐No
Frequent low blood sugars (hypoglycemia)	☐Yes	☐No
Severe hypoglycemia (requiring help from others)	☐Yes	☐No
Unawareness of hypoglycemia	☐Yes	☐No
Waking up at night to urinate	☐Yes	☐No
Acne	☐Yes	☐No
Changes in hat/glove/shoe size	☐Yes	☐No
Enlarged thyroid (goiter)	☐Yes	☐No
Excessive sweating	☐Yes	☐No
Hair growth in unwanted areas	☐Yes	☐No
Hair loss	☐Yes	☐No
Intolerance to cold or heat (if yes, circle one)	☐Yes	☐No
Striae (purple stretch marks in skin)	☐Yes	☐No

Hematologic

Anemia	☐Yes	☐No
Easy bruising	☐Yes	☐No
Easy bleeding	☐Yes	☐No
Enlarged lymph nodes	☐Yes	☐No

Patient Name: _____ Date: _____

Past Medical History Please check all that apply (include year in which they were first diagnosed)

Diabetes ☐Yes ☐No
- Type I ☐ Type II ☐ Other_____
- Year of diagnosis_____ Age at diagnosis_____
- Last dilated eye exam _____
- Diabetic Ketoacidosis or Coma? ☐Yes ☐No
- Damage to eyes from diabetes? ☐Yes ☐No
- If yes, did you have laser therapy? ☐Yes ☐No
- Damage to kidneys from diabetes? ☐Yes ☐No
- Damage to nerves from diabetes? ☐Yes ☐No
- History of diabetic foot ulcers? ☐Yes ☐No

Eyes (circle if you have any of the following):
- Cataracts Glaucoma Macular Degeneration
- Hx Eye surgery Hx Laser therapy

Adrenal Insufficiency ☐Yes ☐No
Alzheimer ☐Yes ☐No
Anorexia or Bulimia ☐Yes ☐No
Anxiety Disorder ☐Yes ☐No
Arthritis (Osteoarthritis) ☐Yes ☐No
Asthma ☐Yes ☐No
Autoimmune Disease ☐Yes ☐No
- If yes, what type?

Bipolar Disorder ☐Yes ☐No
Blood Transfusions ☐Yes ☐No
- If yes, when?

Chronic Kidney Disease ☐Yes ☐No
Clotting Disorder ☐Yes ☐No
Congenital Heart Defects ☐Yes ☐No
Coronary Artery Disease ☐Yes ☐No
- Have you had a Heart Attack? ☐Yes ☐No
- If yes, when?

COPD (Emphysema) ☐Yes ☐No
Cystic Fibrosis ☐Yes ☐No
Depression ☐Yes ☐No
Dialysis ☐Yes ☐No
Erectile Dysfunction ☐Yes ☐No
Fibromyalgia ☐Yes ☐No
Foot Ulcers ☐Yes ☐No
GERD (reflux problems) ☐Yes ☐No
Head Injury/Concussion ☐Yes ☐No
Heart or Valve Defects ☐Yes ☐No
Hemochromatosis ☐Yes ☐No
Hepatitis ☐Yes ☐No
HIV or AIDS ☐Yes ☐No
Hyperlipidemia (high cholesterol) ☐Yes ☐No
Hypertension (high blood pressure) ☐Yes ☐No
Hypogonadism ☐Yes ☐No
Irregular Heart Rhythm ☐Yes ☐No
Liver Disease ☐Yes ☐No
Long-Term Steroid Use ☐Yes ☐No
Kidney Failure or Dysfunction ☐Yes ☐No
Kidney Stones ☐Yes ☐No
Malignancy (Cancer) ☐Yes ☐No
- If yes, where/what type?
- Did you receive chemotherapy ☐Yes ☐No
- Did you receive radiation therapy ☐Yes ☐No

Obstructive Sleep Apnea ☐Yes ☐No
Organ Transplant ☐Yes ☐No
- If yes, what organ?

Osteopenia/Osteoporosis ☐Yes ☐No
Pancreatitis ☐Yes ☐No
Peripheral Artery Disease ☐Yes ☐No
Pituitary Tumor/ Dysfunction ☐Yes ☐No
Polycystic Ovary Syndrome ☐Yes ☐No
Rheumatoid Arthritis ☐Yes ☐No
Sarcoidosis ☐Yes ☐No
Schizophrenia ☐Yes ☐No
Seizure Disorder ☐Yes ☐No
Sickle Cell ☐Yes ☐No
Skin Disorders ☐Yes ☐No
Stroke/ TIA ☐Yes ☐No
Thyroid Disease:
- Hyperthyroidism ☐Yes ☐No
- Hypothyroidism ☐Yes ☐No

Thyroid Nodules ☐Yes ☐No
Thyroid Cancer ☐Yes ☐No
Other: _____

Patient Name: _____ Date: _____

Past Surgical History (please list surgical procedure/date):

1._____ **6.** _____

2._____ **7.** _____

3._____ **8.** _____

4._____ **9.** _____

5._____ **10.**_____

Have you had any of the following vaccinations? Check all that apply and specify when last received

.☐ Influenza _____ ; ☐ Pneumonia _____; ☐ Tetanus _____

Social History: Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widow

Do you have any children: ☐ Yes ☐ No If yes, how many: ____ Biological ____ Adopted or Step-Children

What is your current profession: _____

Tobacco Use: ☐ None Quite Date: _____

☐ Pipe/Cigar ☐Cigarettes Packs/Day: _____ Number of years smoked: _____

☐ Smokeless Tobacco ☐ Electronic or E-Cigarettes ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ In Recovery Amount per week:_____

Drug Use: ☐ None ☐ Past Use ☐ Current Use

☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club Drugs

Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

Obstetric/Gynecological history

If you are female, have you ever been pregnant? ☐Yes ☐No If yes, please describe

Number of pregnancies? _____ Number of live births? _____ Number of miscarriages or abortions? _____

Age of onset of menstrual cycles? _____ Age of onset of menopause? _____ ☐N/A

Are your periods regular? ☐Yes ☐No If no, please describe_____

Date of your last menstrual period _____

Have you ever taken birth control pills, or used birth control patches or implants? ☐Yes ☐No

If yes, what did you take and or how long? _____

Have you ever been on hormone replacement therapy? ☐Yes ☐No

If yes, what did you take and or how long? _____

Have you ever had your tubes tied? ☐Yes ☐No If yes, when? _____

Have you ever had your uterus removed (hysterectomy)? ☐Yes ☐No

If yes, why? _____; when? _____; were your ovaries removed? ☐Yes ☐No

Patient Name: _____ Date: _____

Family Medical History:

Please mark those relatives with diabetes

RELATIVE	DIABETES
Mother	
Maternal Grandmother	
Maternal Grandfather	

RELATIVE	DIABETES
Father	
Paternal Grandmother	
Paternal Grandfather	

If you have any siblings please tell us how many, and if any of them have diabetes:

RELATIVE	# with diabetes	# without diabetes
Maternal Aunts & Uncles		
Paternal Aunts & Uncles		

If you have any siblings please tell us how many, and if any of them have diabetes:

RELATIVE	# with diabetes	# without diabetes
Sisters		
Brothers		

If you have any biological children please tell us how many, and if any of them have diabetes:

RELATIVE	# with diabetes	# without diabetes
Daughters		
Sons		

Do any of your family members have the following disorders (if yes, please mark those who do):

Cancers ☐Yes ☐No If yes, who & what type_____
_____

Chronic Kidney Disease ☐Yes ☐No If yes, who _____

Congestive Heart Failure ☐Yes ☐No If yes, who _____

Genetic Disorders ☐Yes ☐No If yes, who/what type_____

Heart Attacks before age 55 ☐Yes ☐No If yes, who _____

Hemochromatosis ☐Yes ☐No If yes, who _____

High Blood Pressure ☐Yes ☐No If yes, who _____

High Cholesterol ☐Yes ☐No If yes, who _____

Hormonal Disorders ☐Yes ☐No If yes, who/what type _____

Kidney Disease ☐Yes ☐No If yes, who _____

Lupus (SLE) ☐Yes ☐No If yes, who _____

Osteoporosis ☐Yes ☐No If yes, who _____

Pituitary Disorder ☐Yes ☐No If yes, who _____

Rheumatoid Arthritis ☐Yes ☐No If yes, who _____

Stroke ☐Yes ☐No If yes, who _____

Thyroid Conditions ☐Yes ☐No If yes, who _____
_____

Other conditions ☐Yes ☐No If yes, who & what type _____