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.**_____

Patient Name: _____ **Date:** _____

4. _____ **12.** _____

5. _____ **13.** _____

6. _____ **14.** _____

7. _____ **15.** _____

8. _____ **16.** _____

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	Wheezing	□Yes	□No
Weight Gain (unintentional)	□Yes	□No	**Gastrointestinal**		
Appetite Changes (↑ or ↓)	□Yes	□No	Heartburn or Indigestion	□Yes	□No
Fatigue (profound)	□Yes	□No	Vomiting or nausea	□Yes	□No
Fever	□Yes	□No	Swallowing difficulty	□Yes	□No
Night sweats	□Yes	□No	Abdominal pain	□Yes	□No
Irritability	□Yes	□No	Blood in your stool	□Yes	□No
Eyes			Constipation	□Yes	□No
Do you wear glasses or contacts (circle one if yes)	□Yes	□No	Diarrhea or frequent bowel movements	□Yes	□No
Dry eyes	□Yes	□No	**Genitourinary**		
Eye pain or drainage	□Yes	□No	Blood in your urine	□Yes	□No
Visual Changes	□Yes	□No	Urinary Retention	□Yes	□No
ENT/Mouth			Incontinence	□Yes	□No
Ear pain or drainage	□Yes	□No	Erection problems	□Yes	□No
Frequent sinus infections	□Yes	□No	Irregular menstrual cycles	□Yes	□No
Hearing Changes or loss	□Yes	□No	Vaginal discharge or bleeding	□Yes	□No
Cardiovascular			**Musculoskeletal**		
Chest pain or heaviness	□Yes	□No	Broken bones	□Yes	□No
Palpitations or rapid heart beat	□Yes	□No	Joint pain or swelling	□Yes	□No
Exertional shortness of breath	□Yes	□No	Muscle aches	□Yes	□No
Shortness of breath when lying flat in bed	□Yes	□No	Muscle weakness	□Yes	□No
Swelling of feet or legs	□Yes	□No	**Breasts**		
Respiratory			Masses or lumps	□Yes	□No
Blood in your sputum	□Yes	□No	Nipple discharge	□Yes	□No
Coughing (lasting > 3 months)	□Yes	□No	**Neurologic**		
			Seizures	□Yes	□No
Shortness of breath	□Yes	□No	Headaches	□Yes	□No
			Slurred speech	□Yes	□No

Patient Name: _____ Date: _____

Pain or burning in legs or feet	□Yes	□No	Acne	□Yes	□No
Numbness or tickling in legs or feet	□Yes	□No	Changes in hat/glove/shoe size	□Yes	□No
Psych			Enlarged thyroid (goiter)	□Yes	□No
Anxiety without clear explanation	□Yes	□No	Excessive sweating	□Yes	□No
Sadness lasting for days or weeks	□Yes	□No	Hair growth in unwanted areas	□Yes	□No
Sleep disturbance	□Yes	□No	Hair loss	□Yes	□No
Diabetes/Endocrine			Intolerance to cold or heat (if yes, circle one)	□Yes	□No
Increased thirst	□Yes	□No	Striae (purple stretch marks in skin)	□Yes	□No
Increased urination	□Yes	□No	**Hematologic**		
Frequent low blood sugars (hypoglycemia)	□Yes	□No	Anemia	□Yes	□No
Severe hypoglycemia (requiring help from others)	□Yes	□No	Easy bruising	□Yes	□No
Unawareness of hypoglycemia	□Yes	□No	Easy bleeding	□Yes	□No
Waking up at night to urinate	□Yes	□No	Enlarged lymph nodes	□Yes	□No

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

s, what type?

Disorder □Yes □No

ansfusions □Yes □No

s, when?

Kidney Disease □Yes □No

Disorder □Yes □No

al Heart Defects □Yes □No

Artery Disease □Yes □No

e you had a Heart Attack? □Yes □No

s, when?

Emphysema) □Yes □No

brosis □Yes □No

on □Yes □No

□Yes □No

Dysfunction □Yes □No Fibromyalgia

□Yes □No

ers □Yes □No

eflux problems) □Yes □No

Head Injury/Concussion □Yes □No

Heart or Valve Defects □Yes □No

Patient Name: _____ **Date:** _____

Hemochromatosis	□Yes	□No	Osteopenia/Osteoporosis	□Yes	□No
Hepatitis	□Yes	□No	Pancreatitis	□Yes	□No
HIV or AIDS	□Yes	□No	Peripheral Artery Disease	□Yes	□No
Hyperlipidemia (high cholesterol)	□Yes	□No	Pituitary Tumor/ Dysfunction	□Yes	□No
Hypertension (high blood pressure)	□Yes	□No	Polycystic Ovary Syndrome	□Yes	□No
Hypogonadism	□Yes	□No	Rheumatoid Arthritis	□Yes	□No
Irregular Heart Rhythm	□Yes	□No	Sarcoidosis	□Yes	□No
Liver Disease	□Yes	□No	Schizophrenia	□Yes	□No
Long-Term Steroid Use	□Yes	□No	Seizure Disorder	□Yes	□No
Kidney Failure or Dysfunction	□Yes	□No	Sickle Cell	□Yes	□No
Kidney Stones	□Yes	□No	Skin Disorders	□Yes	□No
Malignancy (Cancer)	□Yes	□No	Stroke/ TIA	□Yes	□No
If yes, where/what type?			Thyroid Disease:		
Did you receive chemotherapy	□Yes	□No	Hyperthyroidism	□Yes	□No
Did you receive radiation therapy	□Yes	□No	Hypothyroidism	□Yes	□No
Obstructive Sleep Apnea	□Yes	□No	Thyroid Nodules	□Yes	□No
Organ Transplant	□Yes	□No	Thyroid Cancer	□Yes	□No
If yes, what organ?			Other: _____		

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

Patient Name: _____ **Date:** _____

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

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		

Patient Name: _____ **Date:** _____

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 _____