Endocrine & Metabolic Health Services New patient intake form

Name: _____

Date of Birth:

1.Who may we thank for referring you to our clinic? .

2. What is your chief concern that you would like addressed today?

3. What symptoms are you currently having (check all that apply. Write in any additional symptoms in the space below)?

- □ Hoarseness
- □ Difficulty swallowing
- □ Neck pain
- □ Fatigue
- □ "Brain fog"
- □ Depressed mood
- □ Anxiety
- □ Trouble falling asleep
- □ Trouble staying asleep
- □ Low sex drive
- □ Cold intolerance
- □ Heat intolerance
- □ Weight loss
- □ Weight gain
- □ breast tendernes
- □ Constipation
- □ Frequent bowel movements
- □ Hair loss
- □ Itchy skin
- □ Rash
- □ Light sensitivity
- □ Eye pain / grittiness
- □ Blurry vision
- □ Excess hair growth
- □ Nipple discharge
- □ Hand tremor/shaking
- □ Palpitations (heart racing)
- □ Muscle weakness
- □ other symptoms (please describe)

4. Do you have any history of the following?

□ Thyroid surgery □ Thyroid Cancer □ Thyroid nodules □ Thyroid biopsy date, (if applicable) _____.

□ Radiation exposure □ Radioactive Iodine □ Last thyroid ultrasound date (if applicable)_____.

5. Are you currently taking any of the following?

- □ Levothyroxine
- □ Synthroid
- □ Armour thyroid
- □ Nature thyroid
- □ Cytomel
- □ Tirosint
- □ "thyroid support" pill
- □ iron pills
- □ calcium pills
- □ birth control pills
- □ estrogen
- □depo provera
- □ nuvaring
- □ mirena or copper IUD
- □ testosterone
- □ DHEA
- □ progesterone
- □ bio identical hormones
- □ biotin
- □ skin or hair vitamin
- □ ashwagandha
- □ "adrenal support" pill
- □ prednisone
- □ hydrocortisone
- □ steroid injections
- □ opiate pain medications

6. Have you *ever* taken any of the following medications?

- □ Amiodarone
- □ Lithium
- □ Phenytoin
- □ Methimazole /PTU
- □ Sunitinib (sutent)
- □ Sorafenib (nexavar)
- □ Imatinib (gleevec)
- □ Ipilimumab (Yervoy)
- □ Nivolumab (opdivo)
- □ Pembrolizumab (Keytruda)

7. Do you have any of the following health conditions?

- □ Hypertension
- □ Heart failure
- □ COPD/emphysema
- □ Lupus
- □ Bariatric surgery
- □ High cholesterol
- □ Atrial fibrillation
- □ Rheumatoid arthritis
- □ Cancer _____
- □ Anemia
- □ Sleep apnea
- □ Coronary artery disease
- □ Ulcerative colitis/Crohns
- □ Liver disease
- □ Pituitary tumor
- □ Adrenal insufficiency
- □ Low testosterone
- □ Celiac disease
- □ Adrenal nodule
- □ PCOS
- □ Osteoporosis
- □ Hyperparathyroidism
- □ Kidney stones
- □ High calcium
- □ Low vitamin D

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Contd…

□ Chronic fatigue □ Fibromyalgia □ Anxiety disorder □ Domestic violence
□ Restless leg syndrome
□ Diabetes □ Endometriosis □ Eating disorder □ Schizophrenia
□ Bipolar disorder
□ Other health conditions (please write in):

8. Please answer the following questions about your sleep:

What time do you go to bed?____ What time do you get up to start the day? _____ How may times do you awaken at night?_____

9. Please check any boxes that apply to you. These questions are also related to sleep.

□ Trouble falling asleep □ Snoring □ Gasping during sleep □ Pauses in breathing
□ Dry mouth
□ Drooling on pillow □ Morning headache □ Racing thoughts at night □ Fall asleep during day □ Use medication to sleep
□ I am on CPAP or BiPAP □ I've had a sleep study in the past

10. Menstrual History (women only)

Age at start of periods_____.
First day of last menstrual period_____ Are periods regular? □ Yes □ No
Number of day in cycle_____.
Total number of pregnancies_____ Number of Live births___Miscarriages____Abortions_____.
Are you menopausal? □ Yes □ No (If yes, what age):_____.
Have you had a hysterectomy? □ Yes □ No Have you had an oopherectomy? □ No □ one ovary removed □ both ovaries removed

11. What other medications do you take? (please write in below, or bring a list of your medications to your appointment)

12. Any surgeries (please list month and year if you remember)?

13 Do you have any medication allergies?

□ No known drug allergies □ I am allergic to (please list):

14. Do you have any other symptoms?

□ Sweats	□ Trouble breathing lying down	□ Trouble with getting erections	□ Hot flashes
□ Headaches	□ Heartburn	□ Decreased sex drive	□ Change in ring or shoe size
□ Change in hearing	□ Nausea	□ Urinary urgency	□ Purple stretch marks
□ Breast discharge	□ Vomiting	□ Itchy skin	□ Bruising easier
□ Shortness of breath	□ Dark stool	□ Rash	□ Bleeding easier
□ Chronic cough	□ Blood in stool	□ Dry Skin	□ Seizures
□ Coughing blood	□ Painful/difficult urination	□ Excessive urination	□ Numbness/tingling in feet
□ Chest pain	□ Blood in urine	□ Excessive thirst	
□ Swelling in your ankles		□ Excess hair growth	

Please turn over for page 3

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15. If you have concerns about weight gain, please complete this next section. Otherwise, you can skip to next section

Age weight became problem _____Highest weight (with age)_____Lowest weight (with age)_____.
Most weight you have ever lost_____Present weight_____Weight goal_____.
What do you think is the cause of your weight problem?

How many times per week do you eat out?

How many non-diet sodas do you drink per week (12 oz can = 1 drink)?

How many glasses of juice, sweet tea, sports drinks do you drink per week?

Do you have any history of the following?
□ Bariatric surgery □ Eating disorder □ Heart disease □ Substance abuse
□ Glaucoma

What is your activity level?
□ Inactive- no regular physical activity with a sit-down job
□ Mild activity – Exercise 20 min 1 - 3x/ week. Or routinely on feet at work walking for most of the day
□ Moderate activity- Exercise 30 - 60 min 3 - 4x/wk.
□ Heavy activity – Exerciser 60+ min 5 - 7x/ wk. Or brick laying, carpentry, general labor, farming, landscaping

16. Family History- ***Please indicate family members with the following health conditions. If you have multiple brothers/sisters, please indicate how many have the condition (eg: if you have 3 brothers and only one had diabetes, then write 1/3***

	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Mat. Aunt	Mat. Uncle	Pat. Aunt	Pat. Uncle
Diabetes	□	□	□	□	□	□	□	□	□	□	□	□
Hypothyroid	□	□	□	□	□	□	□	□	□	□	□	□
Hyperthyroid	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid cancer	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid Nodule	□	□	□	□	□	□	□	□	□	□	□	□
High Calcium	□	□	□	□	□	□	□	□	□	□	□	□
Kidney stone	□	□	□	□	□	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□	□	□	□	□	□
Kidney disease	□	□	□	□	□	□	□	□	□	□	□	□
Heart attack	□	□	□	□	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□	□	□	□	□
Pituitary tumor	□	□	□	□	□	□	□	□	□	□	□	□
Colon cancer	□	□	□	□	□	□	□	□	□	□	□	□
Breast cancer	□	□	□	□	□	□	□	□	□	□	□	□
Ovarian cancer	□	□	□	□	□	□	□	□	□	□	□	□
Leukemia or lymphoma	□	□	□	□	□	□	□	□	□	□	□	□
Blood clots	□	□	□	□	□	□	□	□	□	□	□	□

17. Social History

A. Alcohol use (1 drink: 5 oz wine, 12 oz beer, 1.5 oz spirit)? □ Never □ less than 7 drinks/week □ 7 – 14 drinks/week □ over 14 drinks/week
B. Do you smoke? □ Never □ Former □ Current If yes, how many cigarettes per day? _____
C. Do you use recreational drugs? □ Never □ Former □ Current If yes, which drugs?
D. How many children do you have? □ None □ One □ two □ three □ four □ other _____
E. Highest level of education? □ Did not complete highschool □ highschool □ some college □ 2yr college □ 4yr college □ post-graduate
F. Occupation and employer:

Thank you for taking the time to complete this history form