ENDOCRINOLOGY T&S

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Clinical questionnaire

_____ _____

Last Name First Name Date

_____

Reason for today's visit When did your present illness commence?

Medication you presently are taking:

1. _____ 2. _____
Medication, strength, dosage Medication, strength, dosage

3. _____ 4. _____
Medication, strength, dosage Medication, strength, dosage

5. _____ 6. _____
Medication, strength, dosage Medication, strength, dosage

7. _____ 8. _____
Medication, strength, dosage Medication, strength, dosage

_____

Do you have allergies to any medication Do you have allergies to anything else, if yes, please list

_____

Does your mother have any chronic problems? If yes, please list them If deceased, age at death.

_____

Does your father have any chronic problems? If yes, please list them If deceased, age at death.

_____

Do you smoke cigarettes/tobacco? How many? Do you drink alcohol? How many drinks a week?

_____

Do you have your Cardiologist? If yes, provide Name & Telephone Number

_____

(For female patients only) Do you have your OB-GYN? If yes, provide Name & Telephone Number

_____

Did you go to the hospital during the last two years? If yes, which hospital, dates and reason

_____

Did you have any surgery in the past? If yes, what kind