ENDOCRINOLOGY SPECIALISTS OF COLORADO, LLC
MEDICAL QUESTIONAIRE

Doctor A L Date:

Name:		D.O.B.:

Medication Allergies?	Which Medications are you allergic to?	What does it do to you?
Yes or No		

Past Medical History: Please check any of the following which you have had and give approximate date.

	Anemia		Hepatitis or Liver Problems		Prostate Trouble
	Arthritis		Infertility		Rheumatic Fever
	Asthma		Irritable Bowel		Sexual Dysfunction
	Bleeding Disorders		Kidney Stones		Sexually Transmitted Diseases
	Blood Clots		Kidney Disease		Skin Disorders
	Blood Pressure Problems		Malabsorption		Stomach Ulcers
	Bone Fractures		Mental Illness		Strokes
	Cancer		Mitral Valve Prolapse		Tumors
	Cholesterol Problems		Neurological Problems		Thyroid Problems
	Diabetes		Organ Transplant		Tuberculosis
	Emphysema		Osteoporosis		Ulcerative Colitis
	Hearing Problems		Pancreatitis		Urinary Tract Infections
	Heart Disease or Murmurs		Pneumonia		Vision Problems

Please list any additional medical illness you have if not included.

Past Surgical History: Please list any surgeries you have had in the past.

Women
Menstrual History: Please complete the following with regard to your periods.

Age of onset:	Days between cycles:	Regular Y or N
Type: Heavy – Medium – Light	Duration:	Pain:
Birth Control:	Age of menopause:	Menopause: Natural or Surgical

Habits:

Smoking Now: Y or N	How Much?	How long?	Date you quit?
Alcohol:	How Much?	How long?	Date you quit?
Drug Use:	How Much?	How long?	What do you use?
Exercise:	How Much?	How long?	What do you do?

Family History: Please check any of the following which have occurred in your family, and indicate which family member it occurred; Mother, Father, Brother, Sister, Child, Grand Parent, Aunt, or Uncle.

	Anemia		Emphysema		Obesity
	Arthritis		Heart Trouble		Osteoporosis
	Bleeding Disorders		Hepatitis or Liver Problems		Skin Disorders
	Blood Pressure Problems		Kidney Disease		Strokes
	Bone Fractures		Kidney Stones		Stomach Ulcers
	Cancer		Malabsorption		Thyroid Problems
	Cholesterol Problems		Mental Illness		Tuberculosis
	Diabetes		Neurological Problems		Tumors

Please list any additional medical illness that has occurred in your family if not included above:

Doctor A L Date:

Name: D.O.B.:

Please list age of the following. If deaths have occurred, please list at what age and the cause.	
Father:	Sisters:
Mother:	Children:
Brothers:	

Review of Systems: Please check if you are currently or recently experienced any of the following:

Constitutional Symptoms

	Fatigue
	Weakness
	Weight Loss or Weight Gain
	Fevers / Chills / Night Sweats

Eyes

	Eye Pain
	Glasses / Contacts
	Blurred Vision
	Loss of Vision
	Itchy or Watery Eyes
	Red Eyes
	Headaches

Ears, Nose, Mouth, Throat

	Pain in the Ears
	Decreased Hearing
	Ringing in your Ears
	Dizziness
	Infection
	Frequent Colds
	Sinus Congestion or Pain
	Nasal Drainage
	Itching or Hay fever
	Nosebleeds
	Facial Pain
	Tooth or Gum Pain
	Hoarseness
	Sore Throat

Breasts

	Lumps
	Discharge
	Pain
	Self Exams

Endocrine

	Heat or Cold Intolerance
	Excessive Sweating
	Excessive Hunger or Thirst
	Frequent Urination
	Hot Flashes

Respiratory

	Coughing or Wheezing
	Coughing up Blood
	Coughing up Phlegm
	Shortness of Breath
	Pain with Breathing

Cardiovascular

	Shortness of Breath while Lying Flat
	Number of Pillows you Sleep On
	Decreased Ability to Exercise
	Chest Pain
	Rapid Heart Rate or Pounding
	Skipped Heart Beats
	Swelling in your Feet or Ankles

Gastrointestinal

	Abdominal Pain
	Difficulty Swallowing
	Appetite
	Bloating or Belching
	Nausea / Vomiting
	Vomiting Blood
	Constipation or Diarrhea
	Change in Bowel Habits
	Blood in the Stool
	Change in Stool Color or Size
	Food Intolerance

Hematologic/Lymphatic

	Easy Bruising
	Past Transfusions
	Swollen Glands
	Neck Pain or Stiffness

Allergic/Immunologic

	Frequent Infections
	Hay Fever
	Tetanus Shot in Last 5 Years
	Flu Shot in Last Year
	Pneumonia Shot
	Exposure to Tuberculosis

Genitourinary

	Pain or Burning on Urination
	Change in Color/Odor of Urine
	Blood in Urine
	Frequency of Urination
	Urgency of Urination
	Stop and Start Urinating
	Incontinence
	Impotence
	Decreased Libido

Musculoskeletal

	Backache
	Muscle or Joint Aches
	Muscle Weakness or Stiffness
	Muscle or Bone Pain

Neurological

	Fainting or Blackouts
	Pain / Burning in Legs or Feet
	Numbness or Tingling
	Shakes or Tremors
	Seizures

Psychiatric

	Depression
	Thoughts of Suicide
	Nervousness
	Hallucinations
	Tension
	Insomnia

Skin

	Rashes, Sores, Lumps
	Itching, Dryness
	Change in Color
	Changes in your Nails
	Changes in your Hair

Please add anything which is not listed above.