ENDOCRINOLOGY SPECIALISTS OF COLORADO, LLC
MEDICAL QUESTIONAIRE

Doctor L T 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 L T 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.