General Endocrinology Questionnaire

Patient Name:	Date of Birth:	
*PLEASE RETURN COMPLETED FORM VIA Please list any current prescribed medications ar needed, please attach an additional page.	A EMAIL PRIOR TO	
Name of Medications/ Supplements/ Vitamin	s Dose	Frequency
What is your pharmacy name, address ar	nd number?	
2) What medical problems do you have?		
Medical Problem	Year of diagno	
(For ex. High blood pressure)	(For ex. 2005	

3) Do you have any of these medical problems specifically?

Medical history	Yes	No	Year of diagnosis and further details
Diabetes mellitus			
Thyroid disease			
Parathyroid disease			
Pituitary disease			
Adrenal disease			
Osteoporosis/Bone disease			

Medication Allergies		Reaction		
5) Have you had any prior s	urgerie	s? Yes _	No	
Previous Surgerie	es		Month and year	
6) Have you been hospitaliz Hospitalization rea		ore? Yes	No Month and year	
1105pitalization rea	nospitalization reason			
7) Does anyone in your fam	ily have	a histo		
Family History	Yes	No No	ry of the conditions below? Details	
Family History Diabetes mellitus				
Family History Diabetes mellitus Thyroid disease				
Family History Diabetes mellitus Thyroid disease Parathyroid disease				
Family History Diabetes mellitus Thyroid disease Parathyroid disease Pituitary disease				
Family History Diabetes mellitus Thyroid disease Parathyroid disease				

8) Please answer these questions as it pertains to you

Social history	Yes	No	Details
Do you exercise regularly?			minutes per day days per week
Do you (or did) you smoke?			packs per day for years. Quit date
Do you drink alcohol?			drinks per day / week