MOUNT NITTANY
PHYSICIAN GROUP

Endocrinology Patient Questionnaire

Patient Name:________________________________ Date of Birth:________________

In the sections that follow, please provide the requested information. Be as complete as possible.

PAST MEDICAL HISTORY

Please list any significant medical problems, which have required a doctor's care. Include any hospitalizations and dates.

1 ______________________________
2 ______________________________
3 ______________________________
4 ______________________________
5 ______________________________
6 ______________________________

PAST SURGICAL HISTORY

Please list any surgical procedures, which have been performed and their dates.

1 ______________________________
2 ______________________________
3 ______________________________
4 ______________________________
5 ______________________________
6 ______________________________

MEDICATIONS

Please list all medications that you are currently taking. Include the dosages and how many times you take them daily. ***INCLUDE SUPPLEMENTS, HERBAL PREPARATIONS, ETC.***

1 ______________________________
2 ______________________________
3 ______________________________
4 ______________________________
5 ______________________________
6 ______________________________
7 ______________________________
8 ______________________________
9 ______________________________
10 ______________________________
11 ______________________________
12 ______________________________
13 ______________________________
14 ______________________________
15 ______________________________

ALLERGIES

Please list any allergies to medications and the reaction that occurred.

Medication	Reaction

SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No

If so, do you smoke: ☐ filtered cigarettes ☐ non-filtered cigarettes ☐ cigars

Do you use: ☐ chewing tobacco ☐ snuff

How much per day? ______________________________

How many years have you used tobacco products? ______________________________

Do you drink alcohol? ☐ Yes ☐ No

If so, what type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Liquor

How much do you drink per day? ____________ week? ____________

What type of work do/did you do? ______________________________

Are you: ☐ Married or in a stable relationship? ☐ Single? ☐ Divorced / Separated? ☐ Widowed?
☐ It's complicated …

FAMILY HISTORY

Please provide the requested information

Family Member	Age (if living or age at death)	Medical problems
Mother		
Father		
Sister/Brother #1		
Sister/Brother #2		
Sister/Brother #3		
Sister/Brother #4		
Sister/Brother #5		
Sister/Brother #6		
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		
Aunt/Uncle #1		
Aunt/Uncle #2		
Aunt/Uncle #3		
Aunt/Uncle #4		
Aunt/Uncle #5		
Aunt/Uncle #6		

MEN

How many children do you have? ________________

WOMEN - MENSTRUAL HISTORY

Please provide the requested information regarding your menstrual cycles.

Age when you had your first period? ________________

Aside from perhaps the first few, have your periods been fairly regular? ☐ Yes ☐ No

Are you still having periods? ☐ Yes ☐ No

If your periods have been regular...

How many days between cycles (from the first day of bleeding of one period to the first day of bleeding of the next)? ________________

How many days of bleeding do you normally have? ______________

Characterize your bleeding/flow: ☐ Light ☐ Moderate ☐ Heavy

First day of your last menstrual period? ________

If your periods have been irregular...

How frequently do you have menstrual bleeding?____________

Have your periods always been irregular? ☐ Yes ☐ No

If no, when did this change occur?________________

Have your periods stopped completely? ☐ Yes ☐ No When? ________________

WOMEN - OBSTETRICAL HISTORY

Please provide the following information regarding your pregnancies.

How many pregnancies have you had? ______________

Number of live births? ______________

Number of miscarriages? ____________ Abortions? ____________

Pregnancy#	Age at time of pregnancy	Delivery method (vaginal or C-section)	Delivery at # weeks gestation	Sex and weight of Infant	Complications during pregnancy or delivery
1					
2					
3					
4					
5					
6					

REVIEW OF SYSTEMS

Please circle items, which are of concern to you or have been bothersome to you.

GENERAL
Weight gain
Weight loss
Night sweats
Fatigue
Weakness
Fever
Shaking chills
Sweating

HEAD AND NECK
Vision changes
Double vision
Blurry vision
Flashing lights
Eye Pain
Redness of the eyes
Watery/Dry eyes
Hearing loss
Ringing in the ears
Ear pain
Discharge from the ear
Nasal congestion
Nasal discharge
Post-nasal drip
Nosebleeds
Sore throat
Hoarseness
Ulcers/sores in mouth
Tooth problems
Neck pain/stiffness
Dizziness
Room spinning

HEART/CARDIOVASCULAR
Shortness of breath at rest
Shortness of breath with exertion
Waking at night short of breath
Sleeping propped up sitting up
Leg cramps at night
Racing heart/palpitations
Irregular heartbeat
Swelling of the legs/ankles
Lightheadedness/dizziness
Leg cramps while walking
Chest pain at rest
Chest pain with exertion
High blood pressure
Fainting

LUNGS/PULMONARY
Chronic cough
Coughing up blood
Sputum/phlegm production
Wheezing
History of pneumonia
Pain when taking deep breaths
Sneezing
Frequent chest colds or bronchitis

GASTROINTESTINAL
Chronic abdominal pain
Nausea
Vomiting
Vomiting blood
Vomiting bile
Heartburn/acid reflux
Excessive belching/burping
Painful swallowing
Food/liquids getting stuck when swallowing
Constipation
Diarrhea
Dark appearing stools
Light appearing stools
Blood in stools
Painful bowel movements
History of liver problems
Jaundice
Loss of appetite
Hemorrhoids
Abdominal bloating

URINARY
Frequent urination
Infrequent urination
Incomplete voiding
Urine stream difficult to start
Urine cuts off in midstream
Frequent urination at night
Blood in urine
Pain with urination
Foamy appearing urine
History of UTIs
Leakage of urine
Passage of kidney stones
Bedwetting
Pain in kidney area

MALE GENITAL
Prostate problems
Inability to attain or maintain an erection
Discharge from penis
Swelling/lump in testicles
Pain in testicles
Changes in testicular size

MUSCULOSKELETAL
Joint pain
Joint stiffness
Muscle cramping
Muscle aches
Weakness-generalized
Back pain

NEUROLOGIC
Numbness or tingling of extremities
Weakness of arm/leg
change in walking
Slurred speech
Blurred vision
Muscle twitches/jerking
History of seizure
Loss of consciousness
History of stroke
Tremor
Depression
Anxiety
History of mental illness
Memory loss

HEMATOLOGIC
History of anemia
Easy bruising
Easy bleeding
History of blood clots
History of blood transfusion
History of transfusion reaction

ENDOCRINE/HORMONAL
Excessive thirst
Excessive hunger
Excessive urination
Heat/cold intolerance
Thinning of skin
Purple stretch marks
Change in skin color
Craving for salt/iced drink

Thank you very much for taking the time to provide this information. This information will be used to help us focus on current or potential medical problems.

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