Huntington Health Physicians

Endocrinology Questionnaire (Virtual Visit)

In order to help us provide you with better medical care, please complete the following questionnaire to the best of your knowledge. If you have diabetes, please *also* complete the Diabetes Questionnaire.

Name: _____ Date: _____
Birthdate:____/____/_____ Sex: ○M ○F Marital Status: ○Single ○Married ○Divorced ○Widowed
Occupation: _____
Who do you live with?_____

Briefly describe the reason for your visit:

PAST MEDICAL HISTORY Please check if you have had any of the following:

☐ Asthma	☐ Depression	☐ Heart disease	☐ Liver disease	☐ Thyroid disease
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Migraine	☐ Ulcer
☐ Back Problems	☐ Epilepsy	☐ High blood pressure	☐ Osteoporosis	
☐ Blood clots	☐ Emphysema	☐ High cholesterol	☐ Pneumonia	
☐ Cancer, Type:	☐ Gallstones	☐ Kidney disease	☐ Poor circulation	
_____	☐ Gout	☐ Kidney stones	☐ Stroke/Paralysis	

Please list any **other medical conditions** not noted above and approximate dates:
_____ Dates: _____
_____ Dates: _____
_____ Dates: _____
_____ Dates: _____

Please list all **surgeries, hospitalizations, serious accidents** and approximate dates:
_____ Dates: _____
_____ Dates: _____
_____ Dates: _____
_____ Dates: _____

Please list any **allergies to medications** and describe the type of reaction:
_____
_____

MEDICATIONS Please list your current medications:

Medication	Dose	How often?	Medication	Dose	How often?

MEDICATIONS (continued)

Medication	Dose	How often?	Medication	Dose	How often?

Please let us know the contact information of your pharmacy (including name, zip code, and phone number):

Local Pharmacy

Mail Order Pharmacy

FEMALES Menstrual History

Age of onset _____ Cycle every _____ days ◯Regular ◯Irregular Last menstrual period: _____ (Date)

Number of pregnancies: _____ Miscarriages: _____ Abortions: _____ Live Births: _____

HABITS

Exercise: ◯Yes ◯No Type? _____ Duration? _____ Frequency per week? _____

Smoking: ◯Yes ◯No How many packs/day? _____ How many years? _____

Alcohol: ◯Yes ◯No Type/# of drinks?_____ How often?_____

FAMILY HISTORY	Age	Any major illnesses?	If deceased, cause?
Mother	____	_____	_____
Father	____	_____	_____
◯Brother ◯Sister ◯Child	____	_____	_____
◯Brother ◯Sister ◯Child	____	_____	_____
◯Brother ◯Sister ◯Child	____	_____	_____
◯Brother ◯Sister ◯Child	____	_____	_____
◯Brother ◯Sister ◯Child	____	_____	_____
◯Brother ◯Sister ◯Child	____	_____	_____

I certify that the foregoing statements are true to the best of my knowledge. _____

Patient Signature