GREENSBORO ENDOCRINOLOGY

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Initial Assessment

To help us meet your needs, please fill out this entire form to the best of your ability, and be sure we receive it at least 3 business days before your consult appointment so we can prepare for your visit.

Please print legibly. *Completed by* ❑ *Patient* ❑ *Other* _____

General Information

Name: _____ Today's date: _____

❑ Male ❑ Female Birthdate: _____ Age: _____ Appointment date: _____

Who referred you to our practice? _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

❑ Spouse or ❑ Parent Name: _____ With whom do you live? _____

Your employer: _____ Occupation: _____

What hours do you work? _____ Highest education level achieved: _____

Have you ever seen an endocrinologist? ❑ No ❑ Yes If yes, who and when? _____

Possible barriers to learning: ❑ Vision ❑ Hearing ❑ Literacy ❑ Memory ❑ None

Does anyone help you with your health care? ❑ No ❑ Yes. If yes, who? _____

Please list and explain the problem(s) for which you were referred to us:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Current Medications

Please bring all medicine bottles with you

Please list ALL medications (prescription & non-prescription) that you currently take:

	Drug Name	Dose (mg)	When taken (times of day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please list any medications (prescription and non-prescription) that you are **allergic** to, or have had **side effects** from: ❑ None

Drug Name	Describe allergy or side effect

Pharmacy:

Mail order: _____ ❑ Preferred

Local: _____ ❑ Preferred

Other Health History

Do you smoke? ❑ Never did ❑ Quit (when? _____) ❑ Yes

At what age did you start smoking? _____ Now smoke _____ packs per day.

Do you drink alcohol? ❑ No ❑ Yes. If so, what do you drink? How much? How often?

_____

Do you use recreational drugs? ❑ No ❑ Yes. If so, what do you use? How much? How often?

_____

Please list any other past or current medical problems: ❑ None

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

Please list any surgeries (and estimated dates): ❑ None

1.	4.
2.	5.
3.	6.

Primary care provider: _____

Please list any other doctors you see: ❑ None

1.	4.
2.	5.
3.	6.

Symptom Checklist

☐ I am pregnant or may be pregnant

Please check and explain any symptoms you have had recently:

General
- ☐ Appetite increase
- ☐ Appetite decrease
- ☐ Weight loss
- ☐ Weight gain
- ☐ Excessive thirst
- ☐ Fatigue (tired)
- ☐ Unexplained fevers
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Trouble sleeping
- ☐ Trouble concentrating

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Easy bruising
- ☐ Itching
- ☐ Dryness
- ☐ Color changes
- ☐ Hair changes
- ☐ Nail changes
- ☐ Yellow skin or eyes

Eyes
- ☐ Glasses or contacts
- ☐ Vision loss
- ☐ Eye pain
- ☐ Eye redness
- ☐ Blurred vision
- ☐ Double vision
- ☐ Flashing lights
- ☐ Glaucoma
- ☐ Cataracts

Ears
- ☐ Decreased hearing
- ☐ Ringing in ears
- ☐ Earache
- ☐ Ear drainage

Nose
- ☐ Stuffiness
- ☐ Discharge
- ☐ Hay fever
- ☐ Sinus pain

Mouth and Throat
- ☐ Full dentures
- ☐ Partial dentures
- ☐ Bleeding gums
- ☐ Sore tongue
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-healing sores
- ☐ Last dental visit date:

Neck
- ☐ Enlarged thyroid (goiter)
- ☐ Lumps
- ☐ Swollen lymph nodes

Breasts
- ☐ Lumps
- ☐ Pain
- ☐ Discharge
- ☐ Breastfeeding currently
- ☐ Last mammogram date:

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Painful breathing

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain, discomfort or tightness
- ☐ Palpitations (heart racing or skipping)
- ☐ Shortness of breath with activity
- ☐ Difficulty breathing lying down
- ☐ Sudden awakening from sleep short of breath
- ☐ Swelling in legs or feet
- ☐ Calf pain with walking

Gastrointestinal
- ☐ Swallowing trouble
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal bleeding
- ☐ Black stools
- ☐ Last colonoscopy date:

Urinary
- ☐ Frequent urination
- ☐ Urgency
- ☐ Burning or pain
- ☐ Blood in urine
- ☐ Decreased urine flow
- ☐ Incontinence (leaking)
- ☐ Kidney stones (ever)

Reproductive Health
- ☐ Menstrual irregularities
- ☐ Menopause symptoms
- ☐ Sexual problems

Musculoskeletal
- ☐ Muscle pain
- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Neck pain
- ☐ Back pain

Neurologic
- ☐ Headaches
- ☐ Dizziness
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor

Mental Health
- ☐ Nervousness or anxiety
- ☐ Stress
- ☐ Depression

Family History

Please list health problems in your family, such as:

- ✓ Diabetes (include “type 1” or “type 2” and age of diagnosis if known)
- ✓ High cholesterol
- ✓ High blood pressure
- ✓ Heart disease
- ✓ Stroke
- ✓ Thyroid problems
- ✓ Cancer (include type if known)
- ✓ Depression

Include cause of (and age at) death if known.

	Year of Birth	Healthy	Died	Health problems:
Father		❑	❑	
Mother		❑	❑	
Brother 1		❑	❑	
Brother 2		❑	❑	
Brother 3		❑	❑	
Brother 4		❑	❑	
Sister 1		❑	❑	
Sister 2		❑	❑	
Sister 3		❑	❑	
Sister 4		❑	❑	
Son 1		❑	❑	
Son 2		❑	❑	
Son 3		❑	❑	
Son 4		❑	❑	
Daughter 1		❑	❑	
Daughter 2		❑	❑	
Daughter 3		❑	❑	
Daughter 4		❑	❑	

Thank you. Please be sure to return completed form promptly.