Main Line HealthCare
Physician Network

ENDOCRINOLOGY
Health Questionnaire

Today's Date:

Please answer these questions to help us maintain accurate records and provide high quality care.
All information will be kept confidential. Please discuss any question about these items with your doctor or clinical staff.

Patient Name DOB

PROVIDERS OF CARE (referring primary care and other providers)

Name	Speciality	Role	Number
Name	Speciality	Role	Number
Name	Speciality	Role	Number

PREFERRED PHARMACY

Name	Location	Number
Name	Location	Number

Reason for referral to our practice

MEDICATIONS

Please list all your MEDIATIONS (prescriptions, over the counter, vitamins, herbal supplements) **OR** attach a list

Drug Name	Dosage	Frequency/Instructions

ALLERGIES

If you have any allergies to medications, foods, or other substances? If yes, please list each and the reaction you've experienced.

Allergic to	Reaction	Allergic to	Reaction

PAST MEDICAL HISTORY

			Diabetes Issues
☐ High Blood Pressure	☐ Arthritis / Joint Problems	☐ Thyroid Disease	☐ Diabetes
☐ High Cholesterol	☐ Skin Disease	☐ Kidney Disease	☐ Gestational Diabetes
☐ Heartburn / Reflux Problems	☐ Asthma	☐ Kidney Stones	☐ Retinopathy
☐ Heart Attack / MI	☐ Osteoporosis (Need Dentist Info Above)	☐ Blood or Bleeding Disorders	☐ Neuropathy
☐ Heart Failure / CHF	☐ Fractures	☐ Hepatic / Liver Disease	☐ Diabetic Nephropathy
☐ Depression	☐ Autoimmune Disease	☐ Drug Problems	☐ Diabetic Ketoacidosis (DKA)
☐ Anxiety	☐ Allergies / Hay Fever	☐ Alcohol Problems	☐ Foot Ulcer
☐ Cancer (Please list type below)	☐ Prostate Problems	☐ Other (Please explain below)	

Cancer

Other

SURGICAL HISTORY

Operation	Date	Operation	Date
☐ Appendectomy		☐ Thyroid Surgery	
☐ Cholecystectomy (gallbladder out)		☐ Laser Eye Surgery	
☐ Hysterectomy		☐ Other	
☐ Heart Surgery			

PLEASE COMPLETE PAGE 2

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Patient Name DOB

FAMILY HISTORY

Has anyone in your IMMEDIATE family had any of the following illnesses?

Diagnosis	Family Member	Diagnosis	Family Member
Diabetes		Heart Attack / MI	
Thyroid Disease		Stroke of Mini-Stroke / TIA	
Thyroid Cancer		Kidney Disease	
Cancer (list type)		Bleeding Disorder	
High Blood Pressure		Genetic Disorder	
High Cholesterol		Asthma	
Osteoporosis / Thinning Bones		Other (list type)	
Hip Fracture		Other (list type)	

Is your mother alive? ☐ Yes ☐ No If not, age at death and cause of death

Is you father alive? ☐ Yes ☐ No If not, age at death and cause of death

SOCIAL HISTORY

Use tobacco? ☐ Current ☐ Former ☐ Never

If yes, Type: ☐ Cigarettes ☐ Cigars ☐ Pipes Usage/day? Cigarettes/Packs________ Cigars_______ Total Years Used?______________

Ever tried to quit? ☐ Yes ☐ No Year Quit?______________ Longest tobacco free__________________

Relapse reason____ Are you interested in smoking cessation couseling? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, what do you drink? ☐ Beer ☐ Wine ☐ Hard liquor How much/week? _____ glasses _____bottles_____ shots

Do you drink caffeine? ☐ Yes ☐ No If yes, what type / cups per day? ☐ coffee____________ ☐ tea___________ ☐ soda____________

Do you exercise? ☐ Yes ☐ No If yes, what type? __________________________________ Days/week________________

Have you ever used illegal drugs? ☐ Yes ☐ No If yes, what type?____

IMMUNIZATIONS

Have you had any of these IMMUNIZATIONS?

Influenza/Flu ☐ No ☐ Yes, Date______________ Hepatitis B ☐ No ☐ Yes, Date______________

Pheumonia/Pneumovax ☐ No ☐ Yes, Date______________ ____

HEALTH MAINTENANCE

When was your LAST (Please give approximate date)

Nutrition Education____________________________________ Smoking Cessation Counseling__________________________________

WOMEN'S HEALTH

Do you get a menstrual period? ☐ Yes ☐ No If yes, when was your last menstrual period?______________________________

Is it: Regular or Irregular ? (circle one)

Are you menopausal? ☐ Yes ☐ No

Do you have osteoporosis? ☐ Yes ☐ No ☐ Maybe If yes or maybe, please complete the following:

Dentist Name____________________________________ Phone____________________

Last Bone (DEXA) Scan: Date______________________

Performed Where?______________________________________

PLEASE COMPLETE PAGE 3 IF YOU HAVE DIABETES

Main Line HealthCare
Physician Network

Comprehensive Health Questionnaire

DIABETES PATIENTS ONLY

This form is only for patients being seen for diabetes.

Today's Date:

Patient Name DOB

How old were you when you were diagnosed with diabetes? ____________________

What symptoms did you have when you were diagnosed? ____________________

Have you ever been hospitalized for diabetes? When & why? ____________________

How many times a day do you check your sugars? ___________ **FULL NAME** of your glucose meter? ____________________

During the last month, what have your sugars generally been?

Before breakfast	Lowest	Highest	Usual
Before lunch	Lowest	Highest	Usual
Before dinner	Lowest	Highest	Usual
Bedtime	Lowest	Highest	Usual

How many times in a month do you have blood sugars under 70? ________________

What symptoms do you have when your sugar is low? ____________________

List your general mealtimes, including snacks ____________________

Aside from the medication you are taking now have you taken any other diabetes medication?

HEALTH MAINTENANCE

When was your LAST (Please give approximate date)

Diabetes Education____________________ Ophthalmology Consult____________________

Dental Consult____________________ Podiatry Consult____________________