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

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

Diabetes Issues

- ☐ Diabetes
- ☐ Gestational Diabetes
- ☐ Retinopathy
- ☐ Neuropathy
- ☐ Diabetic Nephropathy
- ☐ Diabetic Ketoacidosis (DKA)
- ☐ Foot Ulcer

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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Health Questionnaire

Today's Date:

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_____