ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

Date_____ DOB_____ Age_____ Patient Name_____

PREVIOUS SURGICAL PROCEDURES

			Appx. Date
Tonsillectomy	Yes ____	No ____	_____
Appendectomy	Yes ____	No ____	_____
Hysterectomy	Yes ____	No ____	_____
Cholecystectomy *(removal of Gall Bladder)*	Yes ____	No ____	_____
Other	Yes ____	No ____	_____

REVIEW OF SYSTEMS (*In Last Six Months*)

SKIN

Dry	Yes ____	No ____
Moist	Yes ____	No ____
Rash	Yes ____	No ____
Normal	Yes ____	No ____
Open Wounds	Yes ____	No ____
Excessive Bruising	Yes ____	No ____

CARDIAC / RESPIRATORY

Shortness of Breath	Yes ____	No ____
Chest Pain	Yes ____	No ____
Heart Palpitations	Yes ____	No ____
Persistent Cough	Yes ____	No ____

GASTROINTESTINAL

Ulcers	Yes ____	No ____
Liver Disease	Yes ____	No ____
Diarrhea	Yes ____	No ____
Constipation	Yes ____	No ____
Blood in Stool	Yes ____	No ____

KIDNEYS

Stones	Yes ____	No ____
Kidney Infection	Yes ____	No ____
Bladder Infection	Yes ____	No ____
Blood in Urine	Yes ____	No ____

NEUROLOGICAL

Severe Headaches	Yes ____	No ____
Confusion	Yes ____	No ____
Tingling	Yes ____	No ____
Numbness	Yes ____	No ____

ENDO

Excessive Thirst	Yes ____	No ____
Increased Urination	Yes ____	No ____
Rising to Void, *(more than once a night)*	Yes ____	No ____

General Review

Weight Change	Yes ____	No ____
Extreme Fatigue	Yes ____	No ____
Fainting	Yes ____	No ____
Dizziness	Yes ____	No ____
Impaired Sight	Yes ____	No ____
Nose Bleeds	Yes ____	No ____
Anxiety	Yes ____	No ____

Female Reproductive

Age of Menstruation	_____
Is it Regular	_____
No. of Pregnancies	_____
Children Born Alive	_____
Breast Discharge	_____
Date Last Menstrual Period	_____
Date Last Mammogram	_____

Male Reproductive

Prostate Disorder	Yes ____	No ____
Testicular Mass	Yes ____	No ____
Impotence	Yes ____	No ____

THYROID

Has Voice Changed	Yes ____	No ____
Difficulty Swallowing	Yes ____	No ____
Nodule/Growth of Thyroid	Yes ____	No ____
Painful Thyroid	Yes ____	No ____
Goiter Problem	Yes ____	No ____
Hair - Coarse	Yes ____	No ____
- Normal	Yes ____	No ____
- Thin	Yes ____	No ____
- Loss of	Yes ____	No ____

Vaccination

Tetanus Vaccine *(last 10 years)*	Yes ____	No ____

IMAGING

Thyroid Ultrasound	Yes ____	No ____	MRI of Pituitary	Yes ____	No ____
Thyroid Uptake & Scan	Yes ____	No ____	CT Scan of Pituitary	Yes ____	No ____
Whole Body Scan	Yes ____	No ____	MRI/CT Adrenal	Yes ____	No ____
Parathyroid Scan	Yes ____	No ____	Dexa Scan	Yes ____	No ____