



Endocrinology Associates

OF PRINCETON, LLC

thyroid
diabetes
hormonal disorders
nutrition support

A. PERSONAL INFORMATION

Name:	Gender: M / F	Today's Date:
Date of Birth:	Age:	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> S
Referring Physician:	Primary Physician:	
Other Physicians:		
Occupation:		

B. REASON FOR CONSULTATION

Please indicate the reason for this consultation:

GENERAL MEDICAL INFORMATION

Please list your chronic medical conditions (like hypertension or diabetes):

- 1)
- 2)
- 3)
- 4)
- 5)
- 6)
- 7)
- 8)
- 9)
- 10)

HAS YOUR DOCTOR EVER SAID THAT YOU HAVE A PROBLEM WITH ONE OF THE FOLLOWING GLANDS? IF YES, PLEASE EXPLAIN:

CONDITION	YES	NO	CONDITION	YES	NO
Pituitary:	<input type="checkbox"/>	<input type="checkbox"/>	Pancreas:	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid:	<input type="checkbox"/>	<input type="checkbox"/>	Ovaries:	<input type="checkbox"/>	<input type="checkbox"/>
Adrenal Glands:	<input type="checkbox"/>	<input type="checkbox"/>	Testes:	<input type="checkbox"/>	<input type="checkbox"/>
Parathyroid Glands:	<input type="checkbox"/>	<input type="checkbox"/>			

Please give any details if any conditions are marked "Yes":

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (INCLUDE DETAILS)

Injuries, Accidents, and/or Disabilities:

Hospitalizations:

Surgeries:

Other Major Illnesses or Chronic Health Problems:

Have you ever taken any hormone supplements? If yes, explain:

Are you currently being treated for any medical/psychological problems? If yes, please explain in detail the diagnoses, symptoms, treatment and response to treatment.

D. CURRENT MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS & DOSES), INCLUDE VITAMINS & SUPPLEMENTS

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

E. ALLERGIES (PLEASE LIST ALL DRUG, FOOD, & ENVIRONMENTAL ALLERGIES, INCLUDE YOUR REACTION TO THEM)

F. HABITS – DO YOU EVER USE THE FOLLOWING? IF YES, HOW OFTEN?

ITEM	YES	NO	ITEM	YES	NO
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	Coffee:	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	Tea:	<input type="checkbox"/>	<input type="checkbox"/>
Illicit Drugs:	<input type="checkbox"/>	<input type="checkbox"/>			

G. FAMILY HISTORY

Has anyone in your family ever had an endocrine or hormonal disorder? If yes, please explain:

Please provide your family member’s medical history, if deceased please indicate age and reason:

Mother:
Father:
Paternal Grandmother:
Paternal Grandfather:
Maternal Grandmother:
Maternal Grandfather:
Sibling:
Sibling:
Sibling:
Child:
Child:
Child:

H. REVIEW OF SYSTEMS

Please list any symptoms you would like to discuss with the doctor:

1)
2)
3)
4)
5)
6)
7)
8)
9)
10)

I. NUTRITIONAL/ EXERCISE HISTORY

If you are seeing the doctor for Diabetes or issues concerning weight please detail your usual diet (include beverages):

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

Type of exercise:

Duration of exercise:

Times per week:

Patient's Signature _____

Date _____

Reviewing Physician _____

Date _____