SAN DIEGO COASTAL ENDOCRINOLOGY GROUP, A MEDICAL CORPORATION

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Health Questionnaire

Date:_____

Name:_____ Age:_____ Height:_____

Do you have any allergies to medication? YES__ NO__ If YES, list name(s):_____

Pharmacy:_____ Address:_____Phone Number:_____

Habits:

How much alcohol do you drink on a daily basis? _____

How much do you smoke and for how many years? _____

Do you use recreational drugs? YES__ NO__

Medical History:

Do you have a Thyroid problem? YES__ NO__

If YES, please give details:_____

Have you ever been treated with radiation? YES__ NO__

Do you have any of the following? (Please Check)

____Weight Change

____High Blood Pressure

____Heart Attack

____Palpitations/ Irregular Heart Beat

____Loss of Consciousness

____Numbness or Burning

____Stroke

____High Cholesterol

____Chest Pain

____Heart Failure

____Shortness of Breath

____Infections

Date of last Eye exam by an Ophthalmologist? _____/_____/_____

What other symptoms do you have? _____

_____

If you have Diabetes, Please answer the following:

When were you first diagnosed with Diabetes? _____

Have you ever been hospitalized because of Diabetes, Please give details: _____

_____

If you are on Insulin, when was the Insulin started? _____

What are the results of recent finger-stick glucose test done at home? _____

Hospitalizations:

Date and reasons for Hospitalizations/ Surgeries you have had? _____

_____

Family History:

Who in your family has the following:

____Thyroid Disease ____Heart Disease ____Diabetes ____Cancer

Medications:

List your medications (Including over the counter meds) and dose taken: _____

_____

Females:

Are you having periods? YES___ NO___ Do you have breast milk leakage? YES___ NO___

Are your periods regular? YES___ NO___ Do you have excessive body hair? YES___ NO___