Lexington
ENDOCRINOLOGY
A Lexington Medical Center Physician Practice

132 Sunset Court
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New Patient Questionnaire

Lexington Medical Center

Please complete the following form to the best of your knowledge. If you are unsure of the answer, please leave blank.

Patient Name:			DOB:
Home Phone:	Cell Phone:		Email:
Marital Status:	Address:		
Race:	City:	State:	Zip Code:
Local Pharmacy Name and Address:			
Mail Order Pharmacy Name and Address:			

GENERAL HEALTH	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Reason for Visit:	

PAST MEDICAL HISTORY

	YES	NO	YEAR	COMPLICATIONS
Cancer				
Diabetes				
Blood Disorder				
Heart Disease				
Kidney Disease				
High Blood Pressure				
Liver Disease				
Glandular Disorders				
Skin Disease				
Neurologic Disorders				

OTHER ILLNESSES AND/OR SURGERY

	YEAR	COMPLICATIONS

ALLERGIES	Please specify the type of reaction that you have (i.e. itching, rash, hives, wheezing, swelling, etc)
ALLERGY	REACTION

SOCIAL HISTORY	
OCCUPATION	NUMBER OF YEARS

HABITS		
MARK ALL THAT APPLY	✓	HOW MUCH? (PER DAY/PER WEEK)
Cigarettes/Cigars/Pipes		
Alcohol		
Drugs (Specify Type)		
Smokeless Tobacco Products		
Former Smoker		
Never Smoker		

HAVE ANY RELATIVES HAD THE FOLLOWING:				
	YES	NO	IF YES, WHAT RELATION?	
Diabetes				☐ Maternal ☐ Paternal
High Blood Pressure				☐ Maternal ☐ Paternal
Heart Disease				☐ Maternal ☐ Paternal
Kidney Disease				☐ Maternal ☐ Paternal
Stroke				☐ Maternal ☐ Paternal
Hardening of the Arteries				☐ Maternal ☐ Paternal
Arthritis or Rheumatism				☐ Maternal ☐ Paternal
Goiter				☐ Maternal ☐ Paternal
Cancer				☐ Maternal ☐ Paternal
Seizures				☐ Maternal ☐ Paternal

OTHER INFORMATION

Review of Systems (Mark all that apply)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weakness
- ☐ Fatigue
- ☐ Weight change
- ☐ Insomnia

Head and Face
- ☐ Facial pain
- ☐ Facial pressure

Eyes
- ☐ Eye pain
- ☐ Eye discharge
- ☐ Itchy eyes
- ☐ Change in vision or blurred vision

ENT
- ☐ Sinus trouble
- ☐ Nasal discharge
- ☐ Change in hearing
- ☐ Change in voice
- ☐ Throat or neck pain

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations or heart racing
- ☐ Leg pain with walking or at rest
- ☐ Leg swelling
- ☐ Varicose Veins
- ☐ Heart murmur

Respiratory
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough

Gastrointestinal
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting

Gastrointestinal (continued)
- ☐ Blood in the vomit
- ☐ Blood in stools
- ☐ Tarry black stool
- ☐ Heartburn
- ☐ Food intolerance
- ☐ Hemorrhoids

GU
- ☐ Painful urination
- ☐ Incontinence
- ☐ Bladder pain
- ☐ Blood in urine
- ☐ Testicular pain
- ☐ Nocturia
- ☐ Problems with erection

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Joint swelling, stiffness or change in shape of joint
- ☐ Back pain
- ☐ Recent fracture
- ☐ Loss of height

Skin/Breast
- ☐ Lesions
- ☐ Rash
- ☐ Non-healing wounds
- ☐ Change in skin color
- ☐ Change in skin
- ☐ Breast lumps
- ☐ Breast pain
- ☐ Breast discharge
- ☐ Dry skin
- ☐ Decrease in breast size

Neurologic
- ☐ Headaches
- ☐ Problems with memory
- ☐ Fainting
- ☐ Dizziness

Psychiatric
- ☐ Depression
- ☐ Anxiety

Endocrine
- ☐ Hot flashes
- ☐ Heat or cold intolerance
- ☐ Tremulousness
- ☐ Increase in thirst
- ☐ Increase in appetite
- ☐ Change in menstrual cycles
- ☐ Increase or decrease in hair
- ☐ Goiter
- ☐ Night sweats

Hematologic and Lymphatic
- ☐ No easy bruising
- ☐ Active easy bruising

Obstetrical complications
- ☐ High blood pressure
- ☐ Toxemia
- ☐ Severe hemorrhage
- ☐ Gestational diabetes
- ☐ Child weighing over 9 lb at birth

Genito-Reproductive
- ☐ Decreased sexual desire
- ☐ Discharge from penis
- ☐ Lumps in testicles or scrotum
- ☐ Decrease in testicle size
- ☐ Testicular pain
- ☐ Problems with erection

On set of menstrual periods age _____

Menstrual periods stopped age _____

How far apart are your periods? _____

Are you taking any female hormones?

☐ Yes ☐ No

Date of last eye exam:
Eye doctor/Clinic name:
Date of last dental exam:
Primary/Family doctor:

MEDICATIONS		
MEDICATION NAME	**DOSAGE**	**FREQUENCY**