

MRN:
Patient Name:

(Patient Label)

**GONDA GENERAL ENDOCRINOLOGY
QUESTIONNAIRE**

CONDITIONS: Check (✓) conditions you currently have or have had in the past.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |

MEDICATIONS: List medications you are currently taking	ALLERGIES: To medications or substances

Pharmacy Name: _____ Phone: _____

FAMILY HISTORY: Fill in the health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following diseases:	Relationship to you
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease, Strokes	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Other:	

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HOSPITALIZATIONS:		Reason for Hospitalization and Outcome
Year	Hospital	

SERIOUS ILLNESS/INJURIES	Year	Outcome

Have you ever had a blood transfusion? Yes No
 If Yes, please list approximate dates: _____

PREGNANCY HISTORY: <input type="checkbox"/> N/A			HEALTH HABITS:	
Year of Birth	Sex of Birth	Complications (if any)	Check (✓) which substances you use and describe how often:	
			<input type="checkbox"/> Caffeine	
			<input type="checkbox"/> Tobacco	
			<input type="checkbox"/> Drugs	
			<input type="checkbox"/> Other:	

OCCUPATIONAL CONCERNS: Check (✓) if work exposes you to the following:

<input type="checkbox"/> Stress	Your occupation: _____
<input type="checkbox"/> Hazardous Substances	
<input type="checkbox"/> Heavy Lifting	
<input type="checkbox"/> Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient or Patient Representative _____	Date _____
Signature _____	Date _____ Time _____