PACIFIC PITUITARY DISORDERS CENTER AT PACIFIC NEUROSCIENCE INSTITUTE

NEW PATIENT QUESTIONNAIRE | ENDOCRINOLOGY
KATHERINE ARAQUE, MD

LABEL HERE

NAME: _____ DOB: _____ CELL NUMBER: _____

E-MAIL ADDRESS: _____ EMERGENCY CONTACT: _____ PHONE NUMBER: _____

I came to see Dr. Araque by: ☐ PHYSICIAN REFERRAL NAME: _____ ☐ FRIEND/PATIENT REFERRAL NAME: _____ ☐ MY OWN RESEARCH _____ ☐ OTHER _____

Why are you seeing Dr. Araque?_____

What are your symptoms related to this problem?

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Have you ever been diagnosed with other medical problems? (Please check all that apply):

☐HIGH BLOOD PRESSURE ☐HEART DISEASE (HEART ATTACK) ☐HIGH CHOLESTEROL / HYPERLIPIDEMIA ☐DIABETES ☐ TYPE-I ☐ TYPE-II

☐ LUNG DISEASE / ASTHMA ☐ GASTRO-INTESTINAL PROBLEMS ☐ KIDNEY DISEASE/DIALYSIS ☐ THYROID PROBLEMS

☐ DEPRESSION ☐ CALCIUM DISORDER ☐ CANCER / TYPE? _____ ☐ POLYCYSTIC OVARIES

☐ OTHER ISSUES:_____

Please list any past surgeries and the year performed:

1._____ 3._____

2._____ 4._____

Which doctors need a copy of today's consultation from Dr. Araque? Please provide phone/fax numbers:

1. _____ 2. _____ 3. _____

(P)_____ (P)_____ (P)_____

(F)_____ (F)_____ (F)_____

MEDICATIONS: Are you taking any medications, herbal supplements, biotin, CBD or bioidentical hormones?
☐ YES ☐ NO If yes, please list them below:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Preferred pharmacy:_____

PHONE NUMBER: _____ FAX NUMBER: _____

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ALLERGIES: Are you allergic to any medication? ☐ NO If any, please list them below:

1._____ 2._____
3._____ 4._____
5._____ 6._____

SOCIAL HISTORY:

☐MARRIED ☐SINGLE ☐WIDOW ☐DIVORCED ☐CHILDREN _____

ARE YOU CURRENTLY EMPLOYED? ☐YES ☐NO CURRENT POSITION? _____

ARE YOU DISABLED? ☐YES ☐NO HOW LONG? _____

DO YOU DRINK? ☐YES ☐NO
If yes, how often? _____

DO YOU SMOKE? ☐YES ☐NO,
If yes, how often? _____

FAMILY HEALTH HISTORY: Has anyone in your immediate family (siblings, parents, and children) experienced any of the following conditions, indicate their relationship & age to you in the space below the box:

☐HIGH BLOOD PRESSURE _____AGE_____
☐PITUITARY DISEASE _____ AGE_____
☐LUNG DISEASE/ASTHMA _____AGE_____
☐DIABETES _____ AGE_____
☐HEART DISEASE/HEART ATTACK _____ AGE_____
☐THYROID PROBLEMS _____ AGE_____
☐KIDNEY DISEASE/DIALYSIS _____ AGE_____
☐DEPRESSION _____ AGE_____
☐GASTRO-INTESTINAL PROBLEM _____AGE_____
☐SEIZURES _____ AGE_____
☐CANCER/TYPE? _____AGE_____
☐STROKE _____ AGE_____
☐ HIGH CALCIUM LEVELS _____AGE_____

REVIEW OF SYSTEMS: Please indicate any symptoms that you are experiencing. Mark in the boxes Y-YES, N-NO, D-DON'T KNOW

GENERAL
☐FEVER, CHILLS, SWEATS
☐LOSS OF APPETITE

PSYCHIATRIC
☐DEPRESSION
☐ANXIETY

CARDIO-VASCULAR
☐SHORTNESS OF BREATH
☐IRREGULAR HEART BEAT

SKIN
☐LEG ULCERS/DISCOLORATION
☐BRUISING/BLEEDING TENDENCIES
☐ACNE
☐INCREASED FACIAL/BODY HAIR
☐POST MENOPAUSAL
☐PRE-MENOPAUSAL
☐HYSTERECTOMY

GASTROINTESTINAL
☐NAUSEA/VOMITING
☐DIARRHEA CONSTIPATION/BLOODY STOOL
☐HEARTBURN/INDIGESTION/REFLUX DISEASE
☐POLYPS/COLONOSCOPY

ENT/MOUTH
☐EARACHE/RINGING
☐SINUSITIS, RUNNY NOSE/ALLERGIES
☐TROUBLE SWALLOWING/HOARSNESS

REPRODUCTIVE
☐NORMAL
☐IRREGULAR
☐ABSENT PERIODS

GENITOURINARY
☐INCREASED NUTRITION
☐DIFFICULTY URINATING, BLOOD IN URINE

EYES
☐EYE IRRITATION
☐GLAUCOMA/CATARACT/ EYE SURGERY
☐WEAR GLASSES/CONTACTS

RESPIRATORY
☐ASTHMA, EMPHYSEMA/BRONCHITIS
☐COUGH
☐RECENT CHEST X-RAY
☐TUBERCULOSIS

MUSCULOSKELETAL
☐LEG CRAMPS
☐ARTHRITIS/ARTHRALGIAS/GOUT
☐SOFT TISSUE/BONY TRAUMA
☐TREMOR

PATIENT SIGNATURE: _____ DATE:_____