# PATIENT QUESTIONNAIRE

Name:  
Your phone numbers:  
   Home:  
   Cell:  
   Emergency:  
   Contact Person:  
   Phone number:  
E-Mail address:  
Date:  

How did you find our doctors at Pacific Neuroscience Institute? 
- [ ] Referral from another physician (name):  
- [ ] Referral from a friend or another patient (name):  
- [ ] My own research (explain):  
- [ ] Other:  

Prior to coming to PNI, did you go online to review the Pacific Pituitary Disorders Center website?  
- [ ] Yes  
- [ ] No  

Why are you seeing the doctor today?  

What are your symptoms related to this problem?  
1.  
2.  
3.  
4.  

Have you been diagnosed with other medical problems?  
- [ ] High blood pressure  
- [ ] High cholesterol/ Hyperlipidemia  
- [ ] Lung disease/ Asthma  
- [ ] Gastro-intestinal problems  
- [ ] Depression  
- [ ] Seizures  
- [ ] Pituitary/Hormone disorders  
- [ ] Cancer – type?  
- [ ] Heart disease (heart attack)  
- [ ] Diabetes  
- [ ] Thyroid  
- [ ] Kidney Disease/ dialysis  
- [ ] Alzheimer’s/Parkinson’s disease  
- [ ] Stroke  
- [ ] Brain tumor (benign or malignant)  
- [ ] Other issues  

Please list any past surgeries and the year performed:  
1.  
2.  
3.  

Which doctors need a copy of today’s consultation note from Dr. Kelly/ Barkhoudarian? Please provide phone and fax numbers.  
1.  
2.  
3.  
4.  

### MEDICATIONS

Are you taking any medications? Yes  [ ] No  [ ] If YES please list below:

1.  
2.  
3.  
4.  
5.  
6.  
7.  
8.  

### ALLERGIES:
Do you have any allergies to medications? Yes  [ ] No  [ ] If YES please list below and describe reaction to medication:

1.  
2.  
3.  
4.  

2125 Arizona Ave, Santa Monica, CA 90404  
Phone 310-582-7450 | Fax 310-582-7495 | www.pacificpituitary.org
PACIFIC PITUITARY DISORDERS CENTER
AT PACIFIC NEUROSCIENCE INSTITUTE™

SOCIAL HISTORY
☐ Married  ☐ Single  ☐ Children? Number: ___________
Are you currently employed? Yes ☐ No ☐  Current position: ____________________________________________
Are you disabled? ☐ If YES, how long? ____________________________________________________________
Do you drink alcohol? ☐ If YES, how often? _______________________________________________________
Do you smoke? ☐ If YES, how often? ____________________________________________________________

FAMILY HEALTH HISTORY
Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions?
Indicate their relationship to you in the space next to the box:

☐ Heart disease (heart attack) __________________________________________
☐ Lung disease/ Asthma ________________________________________________
☐ Diabetes __________________________________________________________
☐ Depression _________________________________________________________
☐ Seizures __________________________________________________________
☐ Cancer – type? ___________________________________________________

☐ High blood pressure _________________________________________________
☐ Kidney Disease/ dialysis _____________________________________________
☐ Thyroid problem ___________________________________________________
☐ Alzheimer’s/Parkinson’s disease ______________________________________
☐ Stroke ___________________________________________________________
☐ Other issues ______________________________________________________

REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

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<thead>
<tr>
<th>General</th>
<th>Gastrointestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N Don’t Know</td>
<td>Y N Don’t Know</td>
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<tr>
<td>☐ ☐ ☐</td>
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<table>
<thead>
<tr>
<th>Eyes</th>
<th>Genitourinary</th>
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<tr>
<th>ENT/Mouth</th>
<th>Musculoskeletal</th>
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<tbody>
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<thead>
<tr>
<th>Respiratory</th>
<th>Skin</th>
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<tbody>
<tr>
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<tr>
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<tr>
<th>Psychiatric</th>
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<td></td>
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<tr>
<td>☐ ☐ ☐</td>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td>☐ ☐ ☐</td>
<td></td>
<td>Anxiety disorder</td>
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</table>

Please sign below:

Patient Signature: __________________________________________________________________________

Affix Patient Label Here