FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Endocrinology Health History Questionnaire

Patient Name: _____ Date of Birth: _____/_____/_____

Primary Care Physician: _____

Reason for Visit: _____ Occupation: _____

Current Health Concerns		
☐ Chest pain	☐ Loss of appetite	☐ Muscle weakness
☐ Shortness of breath	☐ Increased appetite	☐ Painful swallowing
☐ Fast heartbeat	☐ Weight loss (lbs.)	☐ Difficulty swallowing
☐ Diarrhea	☐ Weight gain (lbs.)	☐ Depression
☐ Excessive sweating	☐ Body aches/pains	☐ Nervousness
☐ Flushing	☐ Bone pain	☐ Irritability
☐ Itching	☐ Fracture	☐ Fatigue
☐ Brittle nails	☐ Flank pain	☐ Insomnia
☐ Hair loss	☐ Eye pain	☐ Memory issues
☐ Cough	☐ Earache	☐ Poor concentration
☐ Hoarseness	☐ Neck pain	
☐ Other:		

Medical History		
☐ Adrenal Disease	☐ Osteopenia	☐ Kidney Disease
☐ Coronary Artery Disease	☐ Osteoporosis	☐ Neuropathy
☐ Heart Attack	☐ Hyperthyroidism	☐ Stroke
☐ Atrial Fibrillation	☐ Hypothyroidism	☐ Pituitary Disease
☐ Hyperlipidemia	☐ High Parathyroid Hormone	☐ Cancer (please specify)
☐ Hypertension	☐ High Serum Calcium Level	
☐ Diabetes mellitus	☐ Liver Disease	

Surgical History			
Surgery	Year	Surgery	Year
☐ Thyroid Surgery/Biopsy		☐ Mastectomy	
☐ Parathyroid Surgery		☐ Ovary Removal	
☐ Spine/Neck Surgery		☐ Hysterectomy	

Family History				
Diagnosis	Father	Mother	Brother	Sister
Thyroid Cancer				
Elevated Serum Calcium Level				
Elevated Parathyroid Hormone Level				
Osteoporosis				
Kidney Stone(s)				
Diabetes				
Hyperthyroidism				
Hypothyroidism				
Adrenal Disease				
Pituitary Gland Disease				