

**LANCASTER ENDOCRINOLOGY
INFORMATION FOR YOUR PHYSICIAN**

Last name _____ First _____ Middle _____ Date _____
Date of Birth: _____

1. **LIST YOUR CHIEF COMPLAINT** _____
 Self-referred or Consultation requested by Dr. _____
My Primary Care Provider is Dr. _____

2. Have you noticed any of the following lately: (please circle)

Fatigue	Shortness of breath
Night sweats	Nausea or Vomiting
Weight gain more than 10 lbs	Constipation or Diarrhea
Weight loss more than 10 lbs	Menstrual irregularities
Neck mass or neck swelling	Headaches
Chronic cough	Cold or Heat Intolerance
Breast mass or breast discharge	Excessive thirst (polydipsia)
Chest pain	Frequent urination (polyuria)
Palpitations	Other _____

3. List **allergies**, including medications, food:

4. **Family History:**

Diabetes who? _____	Heart Attack who? _____
Thyroid who? _____	Kidney failure who? _____
High blood pressure who? _____	High cholesterol (lipids) who? _____
Stroke who? _____	Cancer (type) _____ who? _____

5. **Medical Problems You** have had: (please circle)

Diabetes how long _____	Osteoporosis
High blood pressure	Stroke
Heart attack	Peptic ulcer disease
Kidney failure	Reflux Esophagitis
Chronic lung disease	Gout
Cancer _____	Depression
Thyroid disease	Other _____

6. List previous operations (dates, hospitals, name of surgeon):

7. Do you use tobacco? _____ In the past? _____ Daily amount _____ How long? _____

8. Do you drink alcohol? _____ In the past? _____ Daily amount _____ How long? _____