Endocrinology Associates
OF PRINCETON, LLC

thyroid
diabetes
hormonal disorders
nutrition support

A. PERSONAL INFORMATION		
Name:		Gender: M / F Today's Date:
Date of Birth:	Age:	Marital Status: ☐ M ☐ D ☐W ☐S
Referring Physician:		Primary Physician:
Other Physicians:		
Occupation:		

B. REASON FOR CONSULTATION
Please indicate the reason for this consultation:

GENERAL MEDICAL INFORMATION
Please list your chronic medical conditions (like hypertension or diabetes):
1)
2)
3)
4)
5)
6)
7)
8)
9)
10)

HAS YOUR DOCTOR EVER SAID THAT YOU HAVE A PROBLEM WITH ONE OF THE FOLLOWING GLANDS? IF YES, PLEASE EXPLAIN:

CONDITION	YES	NO	CONDITION	YES	NO
Pituitary:	☐	☐	Pancreas:	☐	☐
Thyroid:	☐	☐	Ovaries:	☐	☐
Adrenal Glands:	☐	☐	Testes:	☐	☐
Parathyroid Glands:	☐	☐			

Please give any details if any conditions are marked "Yes":

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (INCLUDE DETAILS)	
Injuries, Accidents, and/or Disabilities:	
Hospitalizations:	
Surgeries:	
Other Major Illnesses or Chronic Health Problems:	
Have you ever taken any hormone supplements?	If yes, explain:
Are you currently being treated for any medical/psychological problems? If yes, please explain in detail the diagnoses, symptoms, treatment and response to treatment.	

D. CURRENT MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS & DOSES), INCLUDE VITAMINS & SUPPLEMENTS

E. ALLERGIES (PLEASE LIST ALL DRUG, FOOD, & ENVIRONMENTAL ALLERGIES, INCLUDE YOUR REACTION TO THEM)

F. HABITS – DO YOU EVER USE THE FOLLOWING? IF YES, HOW OFTEN?

ITEM	YES	NO	ITEM	YES	NO
Tobacco:	☐	☐	Coffee:	☐	☐
Alcohol:	☐	☐	Tea:	☐	☐
Illicit Drugs:	☐	☐			

G. FAMILY HISTORY

Has anyone in your family ever had an endocrine or hormonal disorder? If yes, please explain:

Please provide your family member’s medical history, if deceased please indicate age and reason:

Mother:
Father:
Paternal Grandmother:
Paternal Grandfather:
Maternal Grandmother:
Maternal Grandfather:
Sibling:
Sibling:
Sibling:
Child:
Child:
Child:

H. REVIEW OF SYSTEMS

Please list any symptoms you would like to discuss with the doctor:
1)
2)
3)
4)
5)
6)
7)
8)
9)
10)

I. NUTRITIONAL/ EXERCISE HISTORY
If you are seeing the doctor for Diabetes or issues concerning weight please detail your usual diet (include beverages):
Breakfast:
Snack:
Lunch:
Snack:
Dinner:
Snack:
Type of exercise:
Duration of exercise:
Times per week:

Patient's Signature_____________________________ Date_________________

Reviewing Physician_____________________________ Date_________________