DIABETES ASSOCIATES MEDICAL GROUP- ENDOCRINE QUESTIONNAIRE

PATIENT'S NAME: DATE OF BIRTH:_____

Have you been diagnosed with any of the following, please circle or underline: Adrenal Tumors, Prolactinoma, Empty Sella Syndrome, Acromegaly, Craniopharyngioma, Cushing's Syndrome, Diabetes insipidus, Ectopic ACTH Syndrome, Growth Hormone Deficiency, Hypopituitarism, Non Functioning pituitary tumor, Hyperthyroidism, Hypothyroidism, MEN 1, Rathke's Cleft Cyst, TSH Secreting pituitary tumor, LH/FSH Secreting pituitary tumor, meningioma, Histiocytosis X, Sarcoidosis.

Endocrine surgical history

Have you had any adrenal surgery?------ How many times?-----

Have you had any parathyroid surgery?----- How many times?-----

Have you had any pancreas surgery?----- How many times?-----

Have you had any thyroid surgery?----- How many times?-----

Have you had any brain surgery such as Transsphenoidal - Under lip, Transsphenoidal - Through nose, Craniotomy (open brain surgery), magnetic resonance therapy(MRT) assisted surgery, Stealth procedure (computer interactive surgery or image-guided surgery), Endoscopic pituitary procedure (the endoscope is like a microscope that magnifies the operative field and the surgeon watches a video monitor directly in front that displays the image that is coming from the endoscope and allows other people in the operating room to follow the surgery in detail).

How many times did you have pituitary surgery?--------

Have you had any procedure such as Petrosal sinus sampling, Dexamethasone CRH test, Octreoscan, brain or cerebral Angiogram?----------

Are you taking any of these: hormone replacement medication such as Testosterone?----- Estrogen?-----.Dilantin?----- Anti Depressants?----- Bromocriptine (Parlodel)?----- Cabergoline (Dostinex)?----- Cortef?----- Hydrocortisone?-----florinef?----- Prednisone?----- Levothyroxine?----- Octreotide (Sandostatin)?----- Lanreotide?----- Growth Hormone?-----DDAVP?----- Genotropin?---- Humatrope?----- And for how long have you been taking----------

Have you had radiation treatment such as: Gamma Knife?----- Proton beam?----- Cyber Knife (robotic radiotherapy)?-----conventional radiation?----- radioactive seed implantation?----- Peacock system?----- Linac (linear acceleration radiation treatment)?-----How many courses of radiation treatment did you receive?----------

PATIENT NAME: DATE OF BIRTH:

For Women: Have you had a recent change in your cycle? -----Are you taking medication to regulate your cycle?----- Do you or have you suffered from loss of libido?----- Has intercourse now or in the past become painful?------Do you or have you suffered from vaginal dryness?---- Do you a milky breast discharge?-----

Age at your very first menses----------

How frequent are your menses ----------

How many menses do you typically have in a year ----------
Approximately how many menses did you have in the last 12 months?----------

Are your menses fairly regular----------Yes/no

Are your menses irregular----------Yes/no

How many years or months have you had irregular menstrual periods ----------

Were your menses irregular from the time of your first menses----------Yes/no

Does your sister, mother, or aunt have irregular menstrual periods ----------Yes/no

Have you been diagnosed with Polycystic ovarian syndrome----------Yes/no

Do you have enlargement of the clitoris----------Yes/no

Do you have increased libido----------Yes/no

Are you trying to get pregnant?----------do you have reduced fertility?----------

How long have you been trying to get pregnant ----------

# of pregnancies----------# of miscarriages----------# of deliveries----------

For birth control pill users when did you start and when did you stop the pill----------

Date of your last menstrual period----------

Age at menopause----------

What has been your highest non-pregnant body weight ever? ----------

Are you anorexic ----------

What type of exercise do you do and how frequently----------

For Men: Approximate age of puberty?--------- Do you have small testes?----- Do you have low testosterone?----- Do you or have you suffered from impotence?----- Do you have a milky breast discharge?-----Do you have breast tenderness?----- Have you noticed breast enlargement?---------
Are you a body builder-----?

PATIENT NAME: DATE OF BIRTH:

Underline or circle any symptoms that you may have:

failure to lactate following delivery of a baby?----------
engage in excessive stimulation of the nipples?----------
breast milk production/leakage/nipple discharge when not nursing(galactorrhea)?----------
lack or decrease of ability to smell things?----------
Have you had previous brain trauma, severe head injury, concussion, loss of consciousness, brain tumor, previous chemotherapy?----------

Please circle or underline symptoms:

headaches?----------

vision impairment, blurriness, blindness, are you partially or totally blind?----------

Have you had a vision change?-------- Do you have tunnel vision?------- Do you have poor peripheral vision?------ Has pituitary surgery changed your vision?------- Have you had a visual field test?-------Do you have visual field defects, double vision?---------

Chronic nausea or vomiting?----------

Please circle symptoms: Do you have frequent urination?------ are you voiding large quantities of urine?-----do you need to urinate at night?-----do you have excessive thirst, dehydration?------. do you need to wake up at night to drink water?------do you crave ice water?------

Do you or did you take any of the following medications: lithium, amphotericin B, demeclocycline?----------How long ago?----------.

Do you have high levels of calcium in the blood(hypercalcemia) ?----------

Do you have kidney disease such as polycystic kidney disease?----------

Please circle or underline symptoms:

Have you had sudden hair loss? isolated dark brown to light brown patches which tend to remain on one side of the midline), early puberty, short stature, localized bone pain, deformities or fractures, seizures, hearing loss, upper body obesity, thin skin, brown patches of skin (café-au-lait spots)? Darker skin, especially in sun exposed areas?----------

PATIENT NAME: DATE OF BIRTH:

Please circle symptoms. Do you have:

weight gain especially abdominal or upper body?--------

relatively thin arms and legs?--------

change of appearance?------ round or moon-like face?------ flushed red face,------excessive facial hair growth?------- acne?-------

upper back fat build-up or hump (buffalo hump) ?----------

thin easy bruised skin with increased bruising or bruisability?----------

skin stretch marks(striae) on the abdomen, thighs, buttocks, arms and breasts?----------

Are the stretch marks purple in color?----------

skin ulcers?----------

slow healing of cuts, ulcers, insect bites?----------

high blood sugars(diabetes mellitus) ?----------

high blood pressure (hypertension) ?----------

mood swings?-------- depression?------- psychosis?-------insomnia?-------- Irritability?----------

excess hair growth on face, neck, chest, abdomen, and thighs?----------

osteoporosis?----------

hip, rib or vertebral (back) compression fractures?----------

weak and fragile muscles and bones?----------

do you find it difficult to rise from a chair or comb your hair?----------

backache?----------

PATIENT NAME: DATE OF BIRTH:_____

Please circle or underline symptoms:

weight loss?----------

increased appetite?----------

heart palpitations or irregular heartbeat (superventricular tachycardia, atrial fibrillation)

rapid heart rate (tachycardia) ?----------

heat intolerance and increased sweating?----------

tremors?----------

frequent bowel movements?----------

fatigue and muscle weakness?----------

exertional intolerance and shortness of breath ?----------

decreased menstrual flow (oligomenorrhea) ?----------

nervousness and irritability?----------

sleep disturbances (including insomnia) ?----------

changes in vision, eye irritation, double vision, bulging of the eyes?----------

leg edema or swelling?----------

sudden paralysis?----------

any lethargy?----------

weight gain?----------

constipation?----------

puffiness of face and eyes?----------

hair loss ?----------

dry skin?----------

PATIENT NAME: DATE OF BIRTH:

Underline any symptoms that you may have:

growth or enlargement of the hands, feet, or are you bothered by foot pain ?---------- increase in ring or shoe size/ tight shoes or increase in hat size?---------- growth or enlargement of the nose, lips, tongue, face, or jaw, or are you bothered by tooth pain

coarsening of facial features?----------

spreading teeth, bite difficulties (overbite/underbite) ?----------

deepening of voice?----------

Bell's palsy (facial paralysis on one side) ?----------

carpal tunnel syndrome/tarsal tunnel syndrome?----------

joint and bone aches, pains and tenderness, bone spurs, fibromyalgia? ----------

gigantism?---------- Have you had an increase in height? --------

excessive perspiration or sweating?----------

oily skin?----------

Please circle or underline symptoms: Do you suffer from sleep apnea?------- Do you have insomnia or trouble falling asleep?---------Do you have excessive daytime sleepiness?------- Do you snore at night?-------- Have you done a "sleep study"?----------.

Have you ever had a bone density test?----------

When was your last bone density test?----------

What was your age at diagnosis of the endocrine disorder?----------

What was the specialty of the physician who diagnosed you with the endocrine disorder?----------

Are you currently under the care of an endocrinologist?----------

Please see the section on the website for medication list and fill out the form.