Ivy-Joan Madu, M.D., F.A.C.E
Diabetes Associates Medical Group

Hormone Disorder Questionnaire

1234 W. Chapman Ave., Ste. 205
Orange, CA 92868
Tel 714.639.1815 | Fax 714.639.2374

Patient Name/DOB: _____ Date: _____

Hormone History

Do you find it difficult to lose weight? ❒ Yes ❒ No

Are you on an extreme weight loss diet? ❒ Yes ❒ No

Do you have excessive mental or emotional stress? ❒ Yes ❒ No

Do you exercise intensely or engage in prolonged physical exertion? ❒ Yes ❒ No

Do you participate in organized sports? ❒ Yes ❒ No

Do you have Diabetes Insipidus? ❒ Yes ❒ No

Do your family members have infertility issues? ❒ Yes ❒ No

Do your family members have inability to perceive smells? ❒ Yes ❒ No

How much weight have you gained or lost in the past year? _____

At your heaviest body weight, how much did you weigh: _____

Do you have a history of any of the following? ❒ Yes ❒ No then check the box that applies if yes

❒ Previous Chemotherapy
❒ Brain Trauma
❒ Loss of Consciousness
❒ Concussions
❒ Difficult-to-treat Stomach Ulcers
❒ Severe Head Injury
❒ Difficult-to-treat Hypertension
❒ Decreased Sense of Smell
❒ Abnormal Skin Pigmentation
❒ Non-Diabetic Low Blood Sugar
❒ Inability to Perceive Smells

Are you taking any of the following medications? then check the box that applies if yes

❒ Testosterone
❒ Estrogen
❒ Dilantin
❒ Anti-Depressants
❒ Levothyroxine
❒ Cabergoline
❒ Hydrocortisone
❒ Growth Hormone
❒ Cortef
❒ Octreotide
❒ Bromocriptine
❒ DDAVP
❒ Genotropin
❒ Prednisone

Have you had any of the following surgeries? ❒ Yes ❒ No then check the box that applies if yes

❒ Adrenal Surgery ❒ Parathyroid Surgery ❒Pancreas Surgery ❒Thyroid Surgery

Have you had any radiation treatments listed below: ❒ Yes ❒ No then check the box that applies if yes

❒ Gamma Knife ❒ Proton Beam ❒ Peacock System ❒ Conventional Radiation
❒ Radioactive Seed implantation

Have you had any of the following procedures/tests: ❒ Yes ❒ No then check the box that applies if yes

❒ Brain MRI ❒ Petrosal Sinus Sampling ❒ Dexamethasone CRH Test ❒ Cerebral (Brain) Angiogram ❒ Octreoscan

Please state your ancestral race if able to: _____

Have you had any of the brain surgeries listed below: ❒ Yes ❒ No then check the box that applies if yes

❒ Stealth Procedure ❒ Endoscopic Pituitary surgery
❒ Transsphenoidal (through nose/ upper lip) ❒ Craniotomy

Have you been diagnosed with any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Adrenal Tumor	❒ Craniopharyngioma	❒ Rathke's Cleft Cyst	❒ Ectopic ACTH Syndrome
❒ Hyperpituitarism	❒ Hyperthyroidism	❒ Meningioma	❒ Growth Hormone Deficiency
❒ Hypopituitarism	❒ Hypothyroidism	❒ Acromegaly	❒ LH/FSH Secreting Pituitary Tumor
❒ Prolactinoma	❒ Sarcoidosis	❒ MEN 1	❒ TSH Secreting Pituitary Tumor
❒ Cushing's Syndrome	❒ Histiocytosis X	❒ Empty Sella Syndrome	❒ Non-functioning Pituitary Tumor

Do you have any of the following symptoms: then check the box that applies if yes

❒ Acne	❒ Fluid Retention	❒ Exaggerated Mood	❒ Excessive Aggression
❒ Depression	❒ Osteoporosis	❒ Night Sweats	❒ Hot Flashes
❒ Scalp hair Recession	❒ Low Libido	❒ Increase in Libido	❒ Loss of Visual Field
❒ Food Cravings	❒ Dry Skin	❒ Excessive Sweating	❒ Tunnel Vision
❒ Salt Craving	❒ Drowsiness	❒ Easy Bruising	❒ Painful Intercourse
❒ Abdominal Pain	❒ Tremors	❒ Impotence	❒ Deepening of the Voice
❒ Increased Shoe Size as an adult	❒ Mood Swings	❒ Frequent Urination	❒ Unexplained Headaches
❒ Increase in Head Size	❒ Chronic Diarrhea	❒ Hot Flashes	❒ Increased Appetite
❒ Increase in Ring Size	❒Thinning of the Skin	❒ Unexplained Fatigue	❒ Abnormal Stretch Marks
❒ Abnormally Oily Skin	❒ Difficulty Swallowing	❒ Slow Wound Healing	❒ Breast Tenderness/swelling
❒ Nausea/ Vomiting	❒ Difficulty Concentrating	❒ Low Blood Pressure	❒ Abnormally Sensitive Nipples
❒ Ear Pain	❒ Choking Sensation	❒ Rounder face	❒ Milky Breast Discharge

For Females Only

Which of the following describes your menstrual cycle?

❒ Light ❒ Frequent ❒ Heavy ❒ Irregular

Are you experiencing any of the following: then check the box that applies if yes

❒ Frequent Menstrual Cycle ❒ Infrequent Menses ❒ Pre-menstrual Mood Swings
❒ Lack of Menstruation ❒ Vaginal Dryness

Do you have a history of miscarriages? ❒ Yes ❒ No

Do you have a history of infertility? ❒ Yes ❒ No

Approximately how many menstrual cycles did you have in the past 12 months? _____

Does your mother, sister, and or aunt have irregular menstrual cycles? ❒ Yes ❒ No

Have you been diagnosed with polycystic ovarian syndrome (PCOS)? ❒ Yes ❒ No

If trying to conceive, are you having any difficulty getting pregnant? ❒ Yes ❒ No

If currently pregnant, do you have excessive vomiting or morning sickness? ❒ Yes ❒ No ❒N/A

What year was your last pregnancy? _____ ❒N/A

At what age was your first menses ever? _____ ❒N/A

What is the date of your last menstrual cycle? _____ ❒N/A

At what age did you begin menopause? _____ ❒N/A