



OC4501



**THYROID AND PARATHYROID
PROGRAM INITIAL VISIT HEALTH
HISTORY QUESTIONNAIRE**

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Referring MD: _____	Primary/Other MD: _____
Specialty: _____	Specialty: _____
Address: _____	Address: _____
Cite/State/Zip: _____	Cite/State/Zip: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

- Why are you here today? What are your symptoms or problems?

- Have you been treated for this problem before? Yes No if yes, date of last treatment?
- Have you ever been exposed to x-rays or other types of radiation? Yes No
If yes, for what condition(s) were you exposed? Acne or skin problem Dental x-rays
 Enlarged thymus Tonsil or adenoid problem other _____
- Does your work involve handling isotopes, nuclear chemicals or being close to x-ray machines?
 Yes No
- Have you ever been treated for thyroid problems? Yes No If yes, please describe problem:

- Have you ever been treated for a growth or tumor in your thyroid? Yes No
If yes, was it cancer? Yes No what type of treatment did you receive for this growth?
(Check all that apply) Iodine-131 Surgery other _____
Date(s) of treatment _____
Have you ever taken thyroid hormone replacement? Yes No If yes, what dose? _____
Have you ever taken anti-thyroid hormone medications? Yes No If yes, what dose? _____
- Have you ever been treated for any of the following endocrine problems? (Check all that apply)
Adrenal tumor Yes No Pituitary tumor Yes No
Multiple Endocrine Neoplasia (MEN) Yes No Cushing's disease Yes No
Zollinger Ellison syndrome Yes No Diabetes Yes No
- Do any of the following conditions run in your family?
Thyroid Cancer Yes No Thyroid disease Yes No (specify) _____
High calcium Yes No Hyperparathyroidism Yes No
Excessive bleeding Yes No Difficulty with anesthesia Yes No
High blood pressure Yes No Stomach ulcers Yes No
Heart condition Yes No (specify) _____
Pituitary / Adrenal tumor (circle) Yes No

Please list any other conditions: _____



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PLEASE CHECK APPROPRIATE BOXES BELOW

- | | | | |
|---|--|--|---|
| Weight gain / loss (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fatigue or low energy level | <input type="checkbox"/> Yes <input type="checkbox"/> No | ① Stomach / Peptic Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Memory loss or forgetfulness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Abdominal pain / cramps (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Palpitations | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heartburn / reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever or chills (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney stones | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sensitivity to cold | <input type="checkbox"/> Yes <input type="checkbox"/> No | ② Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heat intolerance | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> currently on dialysis | |
| Dry/coarse skin | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> had kidney transplant / date_____ | |
| Abnormal hair loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent urination | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Change in vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone / joint pain (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Neck Pain / tenderness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscle weakness / pain (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | History of bone fracture | <input type="checkbox"/> Yes <input type="checkbox"/> No if yes specify |
| Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Changes in voice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteopenia / Osteoporosis (circle) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain with swallowing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen joints | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty swallowing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mood swings / Irritability | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety / nervousness | <input type="checkbox"/> Yes <input type="checkbox"/> No | 'Foggy' feeling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty sleeping | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ② History of cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | ① Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> skin <input type="checkbox"/> leukemia <input type="checkbox"/> lymphoma | | <input type="checkbox"/> heart attack <input type="checkbox"/> heart failure <input type="checkbox"/> heart transplant | |
| <input type="checkbox"/> other (specify) _____ | | | |
| ① History of stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | ② Excessive bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ③ Liver disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | ① Emphysema, chronic lung disease or chronic bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No if yes specify _____ |
| ① Coronary Artery Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | ① Dementia | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any additional medical issues pertaining to the reason for today's visit in the space provided below:



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Patient Identification

List any previous surgery:

Date: _____ Type: _____ Reason: _____ Hospital: _____
Date: _____ Type: _____ Reason: _____ Hospital: _____
Date: _____ Type: _____ Reason: _____ Hospital: _____

What type of anesthesia have you had?

general regional spinal epidural local none unsure

Have you ever had a severe reaction to anesthesia? (If yes, please describe) Yes No

List your prescribed drugs and over-the-counter drugs, including vitamins, supplements, and inhalers:

Name of Drug	Reason prescribed/taken	Strength	Frequency Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any allergies to: Medications, foods, x-ray dye, latex or other substances? (If yes, please describe)

Yes No _____

Social History/Lifestyle

Occupation: _____ If retired, former occupation: _____

Who lives at home with you? _____

(Women) Are you pregnant? Yes No (Women) are you presently trying to conceive a child? Yes No

Do you smoke? Yes No if yes, how many packs per day? _____
Years smoked: _____ Quit date: _____

Do you consume alcohol? never socially few times a month
 daily average # drinks per day _____

AUTHORIZATION: I AUTHORIZE TRANSFER OF MY MEDICAL RECORDS TO THE OHSU THYROID PARATHYROID PROGRAM AND MY REFERRING PHYSICIANS (LISTED ON FRONT OF PAGE):

Completed By: _____ Relationship (if other than patient): _____

Signature: _____ Date: _____