Asheville Endocrinology Consultants

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Patient Questionnaire

Patient Name: _____ Birthdate: _____
Primary Doctor: _____ Eye Doctor: _____
We can now send you secure patient information on our patient portal. To participate, please provide your email address here:_____ □ No, I do not want electronic access.
Local Pharmacy (with city location): _____
Mail Order Pharmacy:_____ Diabetes Supply Company: _____

Preventative Care Clinical Questions

Do you currently smoke? □ Yes □ No
Did you quit smoking? □ Yes □ No
When was your last Flu Shot? Date:_____ Where:_____

Current Medications

Please list name, dose, and how often you take it. You may attach a list.

1. _____ 9. _____
2. _____ 10. _____
3. _____ 11. _____
4. _____ 12. _____
5. _____ 13. _____
6. _____ 14. _____
7. _____ 15. _____
8. _____ 16. _____

Medical Problems/ Conditions/ Illnesses

(Please circle any and all problems you have/had)

Type II Diabetes Type I Diabetes Unsure Type Diabetes Gestational Diabetes High Cholesterol
Hypothyroidism Hyperthyroidism Thyroid Nodules Kidney Disease Depression
Low Testosterone Osteoporosis Osteopenia Fatigue Hypertension
Atrial Fibrillation COPD Obesity Sleep Apnea Graves Disease
Diabetic Neuropathy Erectile Dysfunction Kidney Stones Coronary Artery Disease
Heart Attack Stroke Thyroid Cancer Congestive Heart Failure
Other:_____
_____

Surgical History

Please list Surgery and Year

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____
7. _____ _____

Family Medical History

Please List Family Members who have/had the following conditions:

Diabetes:_____ Early Heart Disease: _____
Thyroid Nodules: _____ Thyroid Disorder: _____
Breast Cancer: _____ Thyroid Cancer: _____
Heart Attack: _____ Hypertension: _____
Other: _____