Chandler Endocrinology, LLC

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Patient Name: _____ **Date: _____**

Review of Systems: (please, mark if you had any of the symptoms/signs, listed below)

Constitutional ☐ **None**
☐ Weight loss _____ lbs ☐ Weight gain _____ lbs ☐ Other _____
☐ Fatigue ☐ Weakness ☐ Chills
☐ Fever ☐ Fatigue
☐ Night Sweats ☐ Malaise
☐ Other _____

Skin ☐ **None**
☐ Rashes
☐ Itching
☐ Changes in hair or nails

Head, Ears, Nose, Mouth, and Throat ☐ **None**
☐ Headaches ☐ Vision Changes ☐ Double Vision
☐ Excessive Tearing ☐ Hearing Loss ☐ Earaches
☐ Vertigo ☐ Tinnitus ☐ Nasal Drainage
☐ Nose Bleeds ☐ Bleeding Gums ☐ Sore Throat
☐ Hoarseness ☐ Swollen Glands ☐ Other _____

Cardiovascular ☐ **None**
☐ Pain or Discomfort in the Chest ☐ Shortness of Breath ☐ Heart Murmur
☐ Rheumatic Fever ☐ Palpitations of the Heart ☐ Leg Swelling
☐ High Blood Pressure ☐ Past Heart Tests ☐ Other _____

Respiratory ☐ **None**
☐ Asthma ☐ Bronchitis ☐ Emphysema
☐ Tuberculosis ☐ COPD ☐ Wheezing
☐ Cough ☐ Last Chest film Date:_____ ☐ Other _____

Gastrointestinal ☐ **None**
☐ Difficulty Swallowing ☐ Abdominal Pain ☐ Constipation
☐ Diarrhea ☐ Heartburn ☐ Nausea
☐ Poor Appetite ☐ Blood in Stools ☐ Hemorrhoids
☐ Jaundice ☐ Liver Problems ☐ Hepatitis **Type: A or B or C**
☐ Gallbladder Problems ☐ Vomiting ☐ Other _____

Genitourinary ☐ **None**
☐ Reduced Strength of Stream ☐ Air in Urine ☐ Rectal Pain
☐ Hesitancy ☐ Prostate Cancer ☐ Penile Pain
☐ Intermittency ☐ Testis Pain ☐ Other _____
☐ Frequent Urination _____Day_____Night(#)____ ☐ Difficulty with Erections
☐ Incomplete Emptying ☐ Reduced Strength of Stream
☐ Urgency ☐ Urinary Tract Infections
☐ Urinary Incontinence ☐ Kidney Pain
☐ Urge Incontinence ☐ Prostatitis
☐ Spontaneous Incontinence ☐ Urethral Discharge
☐ Nocturnal Incontinence ☐ Blood in Semen
☐ Urinary Burning ☐ Penile Curvature
☐ Blood in Urine ☐ Scrotal Pain
☐ Post Void Dribble ☐ Bladder Pain

Musculoskeletal ☐ **None**
☐ Pain in Joints
☐ Limitation of Movement with Extremities
☐ Swelling of Joints
☐ Pains in the Neck
☐ Other _____

Neurological ☐ **None**
☐ Headaches
☐ Loss of Consciousness
☐ Dizzy Spells
☐ Seizures
☐ Paralysis or Weakness
☐ Tremors
☐ Numbness or Tingling of Extremities
☐ Other _____

Psychiatric ☐ **None**
☐ Nervousness
☐ Tension
☐ Mood Swings
☐ Anxiety
☐ Depression
☐ Memory Loss
☐ Other _____

Endocrine ☐ **None**
☐ Thyroid Problems
☐ Heat or Cold Intolerance
☐ Excessive Sweating
☐ Diabetes
☐ Excessive Thirst
☐ Hunger
☐ Other _____

Hematological ☐ **None**
☐ Anemia
☐ Easy Bruising
☐ Bleeds Easily
☐ History of Blood Transfusions
☐ Blood Disorders
☐ Other _____

Past History ☐ **None** **Type**
☐ Tobacco Usage _____ Day _____ Month _____ Years _____
☐ Alcohol – Per _____ Day _____ Week _____ Month _____
☐ Substance Abuse – Per _____ Day _____ Week _____ Month _____
☐ Caffeine Usage - Per _____ Day _____ Week _____ Month _____
☐ Exercise – Per _____ Day _____ Week _____ Month _____

Medicine Allergies ☐ **None**
Please list
Type: _____ Reaction: _____ Type: _____ Reaction: _____

Type: _____ Reaction: _____ Type: _____ Reaction: _____

Previous Surgeries ☐ **None**
Please list type and date of surgery

Type: _____Date: _____ Type: _____Date: _____

Type: _____Date: _____ Type: _____Date: _____

Injuries/Treatments

Type: _____Date: _____ Type: _____Date: _____

Family History	**Type**	**Mother**	**Father**	**Sibling**	**Grandparent**
☐ Heart Disease	_____	☐	☐	☐	☐
☐ Stroke	_____	☐	☐	☐	☐
☐ Diabetes	_____	☐	☐	☐	☐
☐ Seizures	_____	☐	☐	☐	☐
☐ Kidney Disease	_____	☐	☐	☐	☐
☐ Osteoarthritis	_____	☐	☐	☐	☐
☐ Cancer	_____	☐	☐	☐	☐
☐ Prostate Cancer	_____	☐	☐	☐	☐
☐ High Blood Pressure	_____	☐	☐	☐	☐
☐ Mental Illness	_____	☐	☐	☐	☐
☐ Thyroid Disease	_____	☐	☐	☐	☐
☐ Bleeding Disorder	_____	☐	☐	☐	☐
☐ Rheumatoid Arthritis	_____	☐	☐	☐	☐
☐ Other:_____	_____	☐	☐	☐	☐

Medications:

Type:_____ Dosage_____ Frequency _____ Type:_____Dosage_____ Frequency _____

Type:_____ Dosage_____ Frequency _____ Type:_____Dosage_____ Frequency _____

Type:_____ Dosage_____ Frequency _____ Type:_____Dosage_____ Frequency _____

Type:_____ Dosage_____ Frequency _____ Type:_____Dosage_____ Frequency _____

Type:_____ Dosage_____ Frequency _____ Type:_____Dosage_____ Frequency _____

If you have more please list them on the back in the same form.