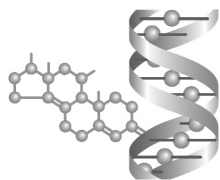


**QUESTIONNAIRE  
FOR PATIENTS**

www.endokrinologen.de

**Endokrinologische Gemeinschaftspraxis**



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Date: \_\_\_\_\_

Name: \_\_\_\_\_ First name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ ☎ Daytime: \_\_\_\_\_ ☎ Evening: \_\_\_\_\_

Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Single  Married  Profession: \_\_\_\_\_

Who has recommended our practice? \_\_\_\_\_

Who is your family doctor / which doctor referred you to us? \_\_\_\_\_

Which complaints have prompted you to consult us? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Questions about your thyroid**

Have you been diagnosed with thyroid disease? No , Yes , for \_\_\_\_\_ years

Enlargement , Nodule , Hyperthyroidism , Hypothyroidism

Has a thyroid operation , or a radioiodine therapy  been performed? When \_\_\_\_\_

Did you receive a contrast medium during the last six months? No , Yes , on account of \_\_\_\_\_

Weight: Have you lost weight? No , Yes  \_\_\_\_\_ kg in \_\_\_\_\_ months

Have you gained weight? No , Yes  \_\_\_\_\_ kg in \_\_\_\_\_ months

Heartbeat: Too fast? No , Yes , pulse/min \_\_\_\_\_ Irregular?

Blood pressure: Too high? No , Yes , (last measurement \_\_\_\_\_ mm Hg),

Too low? No , Yes , (last measurement \_\_\_\_\_ mm Hg)

Bowel movements Frequent? No , Yes , How frequent/day \_\_\_\_\_

Diarrhoea  Constipation

Other: Lump in throat? No , Yes , Difficulty in swallowing , Trembling hands

Hypersensitive to warmth? , Coldness?

Are there any thyroid diseases in the family? No , Yes

**Questions about your bone metabolism/osteoporosis**

Do you suffer from pain in your bones or joints? No , Yes

Have you ever had a bone fracture? No , Yes , \_\_\_\_\_ year(s) ago

Spinal column , Thigh , Forearm , Other \_\_\_\_\_

Has a lower bone density been established? No , Yes , \_\_\_\_\_ year(s) ago

Are you shorter than in the past? No , Yes , Height in passport \_\_\_\_\_ cm, Current height \_\_\_\_\_ cm

Have you received medication for osteoporosis? No , Yes  namely: \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_ \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_ \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

Have you received Cortisone for more than 3 months? No , Yes ,

When was the last time? \_\_\_\_\_

Do you suffer from kidney stones? No , Yes

epilepsy? No , Yes

Is anyone in your family suffering from osteoporosis? No , Yes , Who? \_\_\_\_\_

Intake of milk/milk products: Regularly , A lot , Little

Do you engage in any sporting activities? Frequently , Rarely , Never

Do you expose yourself to the sun? Frequently , Rarely , If possible, not at all

Do you currently smoke? No , Yes , \_\_\_\_\_ cigarettes/day, for \_\_\_\_\_ years,

Did you smoke in the past? No , Yes , \_\_\_\_\_ cigarettes/day over \_\_\_\_\_ years

Do you drink alcohol? Regularly , Now and then , Never , How many? \_\_\_\_\_

**PLEASE COMPLETE** ➤

Questions to female patients

How old were you at the time of your first period? \_\_\_\_\_ years old  
When was the first day of your last period ? \_\_\_\_\_  
Is your period regular , irregular , less than  or more than 28 days ?  
Do intermenstrual bleedings occur? No , Yes   
Did you have periods of anorexia? No , Yes , When? \_\_\_\_\_  
Did you have periods of bulimia? No , Yes , When? \_\_\_\_\_  
Are you pregnant? No , Yes , in week \_\_\_\_\_ of pregnancy  
How many pregnancies/births have you had? \_\_\_\_\_ How old are the children? \_\_\_\_\_  
How many months in total did you breastfeed? \_\_\_\_\_ months  
Do you currently have milk secretion? No , Yes , for \_\_\_\_\_ months  
Are you suffering from loss of hair , excess hair growth , increased acne ?  
since when? \_\_\_\_\_  
Are you suffering from hot flushes , increased mood swings ? since \_\_\_\_\_  
How old were you when your period stopped? \_\_\_\_\_ years old.  
Was a therapy with female hormones conducted thereafter? No , Yes , over \_\_\_\_\_ years  
Do you take hormonal preparations? If so, which: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Questions to male patients

How many children of your own do you have? \_\_\_\_\_ How old are the children? \_\_\_\_\_  
Do you have any potency problems ? No , Yes , for \_\_\_\_\_ years  
Has a male hormone deficiency been established? No , Yes , when \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

General questions: Height \_\_\_\_\_ cm, Weight \_\_\_\_\_ kg  
Do you suffer from allergies? No , Yes , against \_\_\_\_\_  
Have the following illnesses been established?  
Cancer  since when \_\_\_\_\_ Diabetes  since when \_\_\_\_\_  
High blood pressure  since when \_\_\_\_\_ Coronary heart disease  since when \_\_\_\_\_  
Epilepsy  since when \_\_\_\_\_ High cholesterol  since when \_\_\_\_\_  
Are there any hereditary diseases in the family? No , Yes , which \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you or anyone in your family ever suffered from  
blood clots (thrombosis, pulmonary embolism) or breast cancer? No , Yes   
Did you or do you have any serious illnesses or operations? Which?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which medication are you taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_