

Questionnaire for Patients

Date _____

Name _____ First name _____

Date of Birth _____ ☎ Daytime _____ ☎ Evening _____ ☎ Mobil _____

Fax _____ E-Mail _____ [] 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? Date _____

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, (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

Do you suffer from 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 [] never

Do you currently smoke? [] no [] yes, _____ cigarettes/day, over _____ years

Did you smoke in the past? [] no [] yes, _____ cigarettes/day, over _____ years

Do you drink alcohol? [] regularly [] now and then [] never how many? _____

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 in week _____ of pregnancy

How many pregnancies/births have you had? _____ How old are the children? _____

How many months in total did you breastfeed? _____ month

Do you currently have milk secretion? no yes, for _____ month

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, for _____ 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) no yes, pulmonary embolism no yes, breast cancer no yes

Did you or do you have any serious illnesses or operations? Which? _____

Which medication are you taking:

