Deutsches Endokrinologisches Versorgungszentrum

Fragebogen // **Erstpatient**
Stand 10/2017

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 [ ] Hyperthroidism [ ] Hypothroidism
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 [ ] no [ ] yes, (last measurement _____ mm Hg)
Bowel Movements frequent [ ] no [ ] yes How frequnet/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 familiy? [ ] 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, _____ cigaretts/day over _____ years
Did you smoke in the past? [ ] no [ ] yes, _____ cigaretts/day over _____ years
Do you drink alcohol? [ ] regularly [ ] now and then [ ] never How many? _____

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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 [ ] 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

Heigt _____ cm, Weight _____ kg
Do you suffer from allergies? [ ] no [ ] yes, against _____

How 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:

_____

_____

_____

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