Oregon Health & Science University Hospitals and Clinics

OC4501

THYROID AND PARATHYROID PROGRAM INITIAL VISIT HEALTH HISTORY QUESTIONNAIRE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Referring MD: _____ **Primary/Other MD:** _____

Specialty: _____ Specialty: _____

Address: _____ Address: _____

Cite/State/Zip: _____ Cite/State/Zip: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

1. Why are you here today? What are your symptoms or problems?

   _____

2. Have you been treated for this problem before? ❑ Yes ❑ No if yes, date of last treatment?
3. Have you ever been exposed to x-rays or other types of radiation? ❑ Yes ❑ No

   If yes, for what condition(s) were you exposed? ❑ Acne or skin problem ❑ Dental x-rays

   ❑ Enlarged thymus ❑ Tonsil or adenoid problem ❑ other _____
4. Does your work involve handling isotopes, nuclear chemicals or being close to x-ray machines?

   ❑ Yes ❑ No
5. Have you ever been treated for thyroid problems? ❑ Yes ❑ No If yes, please describe problem:

   _____
6. Have you ever been treated for a growth or tumor in your thyroid? ❑ Yes ❑ No

   If yes, was it cancer? ❑ Yes ❑ No what type of treatment did you receive for this growth?
   (Check all that apply) ❑ Iodine-131 ❑ Surgery ❑ other _____

   Date(s) of treatment _____

   Have you ever taken thyroid hormone replacement? ❑ Yes ❑ No If yes, what dose? _____

   Have you ever taken anti-thyroid hormone medications? ❑ Yes ❑ No If yes, what dose? _____
7. Have you ever been treated for any of the following endocrine problems? (Check all that apply)

   Adrenal tumor ❑ Yes ❑ No Pituitary tumor ❑ Yes ❑ No

   Multiple Endocrine Neoplasia (MEN) ❑ Yes ❑ No Cushing's disease ❑ Yes ❑ No

   Zollinger Ellison syndrome ❑ Yes ❑ No ❶ Diabetes ❑ Yes ❑ No
8. Do any of the following conditions run in your family?

   Thyroid Cancer ❑ Yes ❑ No

   High calcium ❑ Yes ❑ No

   Excessive bleeding ❑ Yes ❑ No

   High blood pressure ❑ Yes ❑ No

   Heart condition ❑ Yes ❑ No (specify)

   _____

   Thyroid disease ❑ Yes ❑ No (specify)

   _____

   Hyperparathyroidism ❑ Yes ❑ No

   Difficulty with anesthesia ❑ Yes ❑ No

   Stomach ulcers ❑ Yes ❑ No

   Pituitary / Adrenal tumor (circle) ❑ Yes ❑ No

Please list any other conditions: _____

_____

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PLEASE CHECK APPROPRIATE BOXES BELOW

Weight gain / loss (circle) ❑ Yes ❑ No
Fatigue or low energy level ❑ Yes ❑ No
Memory loss or forgetfulness ❑ Yes ❑ No
Heart Palpitations ❑ Yes ❑ No
Fever or chills (circle) ❑ Yes ❑ No
Sensitivity to cold ❑ Yes ❑ No
Heat intolerance ❑ Yes ❑ No
Dry/coarse skin ❑ Yes ❑ No
Abnormal hair loss ❑ Yes ❑ No
Change in vision ❑ Yes ❑ No
Neck Pain / tenderness ❑ Yes ❑ No
Cough ❑ Yes ❑ No
Shortness of breath ❑ Yes ❑ No
Changes in voice ❑ Yes ❑ No
Pain with swallowing ❑ Yes ❑ No
Difficulty swallowing ❑ Yes ❑ No
Anxiety / nervousness ❑ Yes ❑ No
Difficulty sleeping ❑ Yes ❑ No

❷ History of cancer ❑ Yes ❑ No
❑ skin ❑ leukemia ❑ lymphoma
❑ other (specify) _____

❶ History of stroke ❑ Yes ❑ No

❸ Liver disease ❑ Yes ❑ No

❶ Coronary Artery Disease ❑ Yes ❑ No

Constipation ❑ Yes ❑ No
❶ Stomach / Peptic Ulcer ❑ Yes ❑ No
Abdominal pain / cramps (circle) ❑ Yes ❑ No
Heartburn / reflux ❑ Yes ❑ No
Kidney stones ❑ Yes ❑ No
❷ Kidney disease ❑ Yes ❑ No
❑ currently on dialysis
❑ had kidney transplant / date_____
Frequent urination ❑ Yes ❑ No
Bone / joint pain (circle) ❑ Yes ❑ No
Muscle weakness / pain (circle) ❑ Yes ❑ No
History of bone fracture ❑ Yes ❑ No if yes specify _____
Osteopenia / Osteoporosis (circle) ❑ Yes ❑ No
Swollen joints ❑ Yes ❑ No
Mood swings / Irritability ❑ Yes ❑ No
'Foggy' feeling ❑ Yes ❑ No
Depression ❑ Yes ❑ No

❶ Heart Condition ❑ Yes ❑ No
❑ heart attack ❑ heart failure ❑ heart transplant

❷ Excessive bleeding ❑ Yes ❑ No

❶ Emphysema, chronic lung disease or chronic bronchitis
❑ Yes ❑ No if yes specify _____

❶ Dementia ❑ Yes ❑ No

Please list any additional medical issues pertaining to the reason for today's visit in the space provided below:

_____

_____

_____

THYROID AND PARATHYROID PROGRAM INITIAL VISIT HEALTH HISTORY QUESTIONNAIRE

***List any previous surgery*:**

Date: _____ Type: _____ Reason: _____ Hospital: _____
Date: _____ Type: _____ Reason: _____ Hospital: _____
Date: _____ Type: _____ Reason: _____ Hospital: _____

What type of anesthesia have you had?

❑ general ❑ regional ❑ spinal ❑ epidural ❑ local ❑ none ❑ unsure

Have you ever had a severe reaction to anesthesia? (If yes, please describe) ❑ Yes ❑ No

List your prescribed drugs and over-the-counter drugs, including vitamins, supplements, and inhalers:

Name of Drug	Reason prescribed/taken	Strength	Frequency Taken

Any allergies to: Medications, foods, x-ray dye, latex or other substances? (If yes, please describe)

❑ Yes ❑ No _____

Social History/Lifestyle

Occupation: _____ If retired, former occupation: _____

Who lives at home with you? _____

(Women) Are you pregnant? ❑ Yes ❑ No (Women) are you presently trying to conceive a child? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No if yes, how many packs per day? _____
Years smoked: _____ Quit date: _____

Do you consume alcohol? ❑ never ❑ socially ❑ few times a month
❑ daily average # drinks per day _____

AUTHORIZATION: I AUTHORIZE TRANSFER OF MY MEDICAL RECORDS TO THE OHSU THYROID PARATHYROID PROGRAM AND MY REFERRING PHYSICIANS (LISTED ON FRONT OF PAGE):

Completed By: _____ Relationship (if other than patient): _____

Signature: _____ Date: _____