advocare | Endocrinology Associates of Princeton

Name_____ Age_____ Date of Birth _____
Referring Physician _____Primary Care Physician_____
Other Physicians _____
How did you hear about us? _____
Reason for visit _____ Date of visit _____

Please only complete the section that pertains to your visit

Thyroid Hormone Dysfunction

Year Diagnosed _____ Is your thyroid ○Underactive ◉Overactive
Type of treatment received _____

Thyroid Nodules

Year Diagnosed _____ How were they found? _____
Have you had a biopsy? ○Yes ○No Results? _____
When was your last Ultrasound? _____

Thyroid Cancer

Year Diagnosed _____ Last Ultrasound _____ Last whole body scan_____
Treatment ☐Surgery Date_____ Details: _____
☐Radioactive Iodine Date_____ Details: _____
☐Add'l treatment Date_____ Details: _____
Any additional imaging (CT scan, PET, Xray) _____

Diabetes

Year Diagnosed _____ If on insulin, date started: _____
If you check your blood sugars… Fasting range _____ Post meal range _____
Do you get many low sugars? _____
Do you have (check any that apply)
☐Heart Disease ☐Kidney Disease ☐Diabetes Eye Disease
☐Numbness or Tingling in Feet (Neuropahty)

Osteoporosis

Year Diagnosed _____ Date of last Bone Density _____
Have you had a fracture? ○Yes ○No Date _____ Treatment _____
Which medications have you used in the past? _____

Other Endocrine Concerns

☐Pituitary Disease ☐Adrenal Disease ☐Polycystic Ovarian Syndrome ☐Trangender
☐Other _____
Year Diagnosed _____Previous Imaging (MRI, CT Scan)_____
Previous treatment (including surgeries) _____

Please list all prescription and over the counter medications/supplements you are taking

Medication	Dosage	How Often	Date Started

Please list your chronic medical conditions (ie high blood pressure, thyroid disease, diabetes)

Medical Condition	Date Diagnosed	Physician

Please list any allergies

Drug	
Food	
Environmental	

Please List Previous Surgeries or Hospitalization

Reason for Surgery or Hospitalization	Date of Surgery or Hospitalization

Please describe the following habits

Tobacco	◉ Never	○ Previously	○ Rarely	○ Occasionally	◉ Daily
Alcohol	◉ Never	◉ Previously	◉ Rarely	◉ Occasionally	◉ Daily
Recreational Drugs	◉ Never	○ Previously	◉ Rarely	○ Occasionally	○ Daily

Please list any medical conditions in your family

Family Member	Living	Deceased	Age	Diseases
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Gradnfather				
Sibling				