Patient Name _____ MRN# _____ Date _____

Center for Endocrine Tumors and Disorders – Patient Intake Form (Dr Goldfarb)

Please complete all questions on each page, even if you must answer "unknown". Please print clearly

Name:_____ **Date of Birth:** _____

Email Address:_____ **Best contact #:** _____

SS#: _____ **Age:** _____ **Occupation**:_____

Marital Status: M ___ W ___ S ___ D___ Separated _____ **Children:** _____

Race: Caucasian ___ African American ___ Asian____ Amer Indian ___ Pacific Islan/Hawaiian ____ Other_____

Ethnicity: Hispanic ____ Non-Hispanic ___

Referring MD:_____ (ph) _____ (fax/email) _____

Primary/Other MD:_____ (ph) _____ (fax/email) _____

Emergency contact: _____ (ph) _____ (email) _____

How did you find Dr. Goldfarb ?: website _____ referral _____ friend _____ (who) _____ Ad _____

MEDICATIONS

Are you on any thyroid medication? Yes _____ Name of Drug: _____ No _____

Do you take any calcium supplementation? Yes _____ Name: _____ No _____

Do you take any vitamin D supplementation? Yes _____ Name of Drug: _____ No _____

Do you take any NSAIDS or blood thinners? Yes _____ Name of Drug: _____ No _____

Other current and recent medications (include OTC and herbs) with dosages (if known**):** _____

_____

_____

MEDICAL/SURGICAL HISTORY

Have you ever been diagnosed with ?

- o Bone fracture
- o Osteoporosis
- o Kidney Stones
- o Stomach or duodenal ulcer
- o GERD (reflux)
- o Other Health Conditions _____
  _____
- o High blood pressure
- o Pancreatitis
- o Decreased kidney function
- o Diabetes
- o Thyroid problem
- o Genetic disease (MEN I/II, VHL, SDHD)

Have you ever had surgery for your ? (please include date, surgeon, hospital, and diagnosis if applicable)

- o Thyroid _____
- o Parathyroid _____
- o Cervical spine _____
- o Carotid artery _____
- o Other operations _____

Patient Name _____ MRN# _____ Date _____

Have you ever been treated with ? (please include date, treating physician, and diagnosis if applicable)

- o Radiation _____
- o Radioactive Iodine _____
- o Steroids _____

PERSONAL HISTORY

Allergies (drug and food): _____

Alcohol Use: Current: # of drinks per Week _____ Past: # of drinks per Week ____ Year Quit ____

Tobacco Use: Current: # of packs per day _____ # of years _____ Never _____

Past: # of packs per day _____ # of years _____ Never _____ Year Quit _____

Oral contraceptive (if female): # years _____

FAMILY HISTORY

Family history of thyroid cancer or disorders: Y _____ N _____ (specify maternal vs. paternal, age and diagnosis):

_____

Family history of other cancers: Y _____ N _____ (specify maternal vs paternal relative, age at diagnosis):

_____

Current Symptoms

Do you experience any of the following ?

- o Pain in the bones (not joints)
- o Feeling tired easily
- o Feeling weak
- o Difficulty getting out of a chair or car
- o Pain in the abdomen
- o Mood swings
- o Feeling depressed
- o Forgetfulness
- o Problems concentrating
- o Feeling irritable
- o Waking up at night 3 or more times to go to the bathroom
- o Being thirsty
- o Itchy skin
- o Increasing constipation
- o Heartburn
- o Sexual dysfunction
- o Problems swallowing
- o Shortness of breath while lying flat
- o Hoarseness
- o Voice changes
- o Swollen neck glands
- o Back pain
- o Weight loss
- o Headaches
- o Palpitations
- o Excessive sweating
- o Racing heart rate
- o Anxiety
- o Tremors
- o Trouble sleeping
- o Flushing
- o Diarrhea
- o Weight gain
- o Leg swelling
- o Salt craving
- o Female – abnormal menstruation