Center for Endocrine Tumors and Disorders
2200 Santa Monica Boulevard, Santa Monica, CA 90404
Office: (310) 829-8751 | Fax: (310) 315-6113 | www.theendosurgeon.com

JOHN WAYNE CANCER INSTITUTE
at Providence Saint John's Health Center

PATIENT QUESTIONNAIRE - Frederick Singer, MD

Name: _____ Date: _____

Your phone numbers: Home: _____ Cell: _____ E-Mail Address: _____

Emergency contact person: _____ Phone number: _____

I came to see Dr. Singer by: _____Referral from another physician (name): _____

_____Referral from a friend or another patient (name): _____

_____ My own research (explain): _____

Other: _____

Why are you seeing Dr. Singer? _____

What are your symptoms related to this problem?

1. _____
2. _____
3. _____
4. _____

Have you been diagnosed with other medical problems?

High blood pressure_____
Heart Disease (Heart Attack) _____
High Cholesterol/Hyperlipidemia _____
Diabetes _____
Lung disease/Asthma_____
Thyroid problems _____
Gastro-intestinal problems _____
Kidney disease/Dialysis _____
Depression _____
Calcium disorder _____
Seizures _____
Stroke _____
Cancer-type? _____
Polycystic Ovaries_____
Other issues _____

Please list any past surgeries and the year performed:

1. _____
2. _____
3. _____

Which doctors need a copy of today's consultation note from Dr. Singer? Please provide phone and fax number:

1. _____
2. _____
3. _____
4. _____

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MEDICATIONS:
Are you taking any medications? Y or N
If YES please list below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ALLERGIES:
Do you have any allergies to medications? Y or N
If YES please list below and describe reaction to medication:

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY:
Married_____ Single_____ Children? _____ Number_____
Are you currently employed? _____ Current position_____
Are you disabled? _____ How long? _____
Do you drink alcohol? _____ If yes, how often? _____
Do you smoke? _____ If yes, how often? _____

FAMILY HEALTH HISTORY:
Has anyone in your immediate family (siblings, parents, children) experienced any of the following conditions? Indicate their relationship to you in the space next to each:

Heart disease (Heart Attack) _____
High blood pressure _____
Lung disease/Asthma _____
Kidney disease/Dialysis _____
Diabetes _____
Thyroid problems _____
Depression _____
Pituitary disease _____
Seizures _____
Stroke _____
Cancer - type _____
Other issue(s) _____

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REVIEW OF SYSTEMS: Please indicate any of the following symptoms you are experiencing:

Y = Yes N = No DK = Don't Know

General

_____Fever, chills, sweats

_____Loss of appetite, weight loss

Eyes

_____Eye irritation/infection

_____Glaucoma/cataract/eye surgery

_____Wear glasses/contacts

ENT/Mouth

_____Earache/ringing

_____Sinusitis, runny nose, allergies

_____Trouble swallowing/hoarseness

Respiratory

_____Asthma, emphysema/bronchitis

_____Cough

_____Recent chest x-ray

_____Tuberculosis

Cardiovascular

_____Short breath

_____Irregular heart beat

_____Irregular periods

Psychiatric

_____Depression

_____Anxiety disorder

Gastrointestinal

_____Nausea/ vomiting

_____Diarrhea/ constipation/ bloody stools

_____Heartburn/ indigestion/reflux disease

_____Polyps/colonscopy

Genitourinary

_____Increased urination

_____Difficulty urinating, blood in urine

Musculoskeletal

_____Leg cramps

_____Arthritis/ arthralgias/ gout

_____Soft tissue/ bony trauma

_____Tremor

Skin

_____Leg ulcers/ discoloration of feet/legs

_____Bruising/ bleeding tendencies

_____Acne

_____Increased facial/body hair

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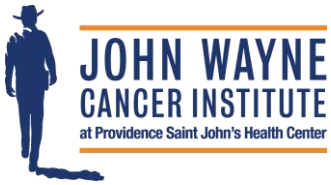

Reproductive

_____Normal periods

_____Absent periods

_____Post-menopause

_____Pre-menopausal

_____Hysterectomy

Please sign below:

Patient Signature: _____ **Date:** _____