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New Patient Intake Paperwork
Prairie Family Medicine
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Hormone & Thyroid Evaluation Form *(to be completed by the patient)*

Name:				Date of Birth:	Date:		
Metabolic, T3 or Adrenal	Current	Past	Chronic	Muscle Tension	☐	☐	☐
Migraines	☐	☐	☐	Easily Frustrated	☐	☐	☐
Constipation	☐	☐	☐	Sweat Easily (Palms/Armpits)	☐	☐	☐
Fluid Retention	☐	☐	☐	Sugar Cravings	☐	☐	☐
Crave Caffeine	☐	☐	☐	Panic Attacks	☐	☐	☐
Dry Coarse Skin	☐	☐	☐	Feeling Overwhelmed	☐	☐	☐
Deepening Voice	☐	☐	☐	Excessive Hunger	☐	☐	☐
Dry or Thinning Hair	☐	☐	☐	Prone to Infections/Sickly	☐	☐	☐
Cold Hands/Feet	☐	☐	☐	Low Blood Pressure	☐	☐	☐
Elevated Cholesterol	☐	☐	☐	Light Headed upon Standing	☐	☐	☐
Low Body Temperature	☐	☐	☐	Racing Mind, Preventing Sleep	☐	☐	☐
Fatigue/Exhaustion	☐	☐	☐	Sluggish in Morning, Slow Start	☐	☐	☐
Brittle/Unhealthy Nails	☐	☐	☐	**Cardiovascular/Respiratory**	Current	Past	Chronic
Fibromyalgia	☐	☐	☐	Chest Pain	☐	☐	☐
Chronic Fatigue	☐	☐	☐	Blood in Sputum	☐	☐	☐
Metabolic or T4	Current	Past	Chronic	Unusual Cough	☐	☐	☐
Decreased Memory	☐	☐	☐	Shortness of Breath	☐	☐	☐
Depression	☐	☐	☐	Swollen Ankles	☐	☐	☐
Anxiety	☐	☐	☐	Rapid Heart Beat	☐	☐	☐
Trouble Multi-Tasking	☐	☐	☐	Leg Pain with Walking	☐	☐	☐
Low Ambition/Motivation	☐	☐	☐	Snoring Excessively	☐	☐	☐
Decreased Concentration	☐	☐	☐	**Gastro-Intestinal**	Current	Past	Chronic
Foggy/Spacey/Muddled Mind	☐	☐	☐	Fluid Retention/Puffy Extremities	☐	☐	☐
Hard to Follow Train of Thought	☐	☐	☐	Bright Blood in Stool	☐	☐	☐
Adrenal	Current	Past	Chronic	Difficulty Swallowing	☐	☐	☐
Fainting/Collapse	☐	☐	☐	Loss of Appetite	☐	☐	☐
Palpitations	☐	☐	☐	Persistent Nausea	☐	☐	☐
Salt Cravings	☐	☐	☐	Bloating	☐	☐	☐

Gastro-Intestinal *continued*	Current	Past	Chronic
Abdominal Pain	☐	☐	☐
Acid Reflux	☐	☐	☐
Recent Change in Bowel Habit	☐	☐	☐
Weight Loss (Unexpected)	☐	☐	☐
Black Tarry Stools	☐	☐	☐
Urinary	Current	Past	Chronic
Blood in Urine	☐	☐	☐
Urgent Urination	☐	☐	☐
Frequent Urination	☐	☐	☐
Hypersensitivity	Current	Past	Chronic
Symptoms are Year-Round	☐	☐	☐
Symptoms are Seasonal	☐	☐	☐
Irritated Tongue	☐	☐	☐
Recurrent Canker Sores	☐	☐	☐
Diarrhea alt. with Constipation	☐	☐	☐
Dandruff/Itchy Scalp	☐	☐	☐
Eczema/Dermatitis	☐	☐	☐
Dizziness	☐	☐	☐
Need Sunglasses in Bright Light	☐	☐	☐
Low Back Pain-Worsens w/ Stress	☐	☐	☐
Immune System	Current	Past	Chronic
Frequent Colds or Flu	☐	☐	☐
Rash Across Face/Cheeks	☐	☐	☐
Patchy Red Rash on Body	☐	☐	☐
Arthritis in Fingers/Hands	☐	☐	☐
Chronic Cough	☐	☐	☐
Sinus Congestion/Infection	☐	☐	☐
Nasal Congestion	☐	☐	☐
Excessive Mucus	☐	☐	☐
Asthma Wheezing	☐	☐	☐
Metabolism	Current	Past	Chronic
Excessive Thirst	☐	☐	☐
Cannot Skip Meals	☐	☐	☐
Headache if Meal is Missed	☐	☐	☐
Craving for Sugar/Carbs	☐	☐	☐
Mid-Afternoon Drowsiness	☐	☐	☐
Low Energy, relieved w/ Food	☐	☐	☐
Jittery/Irritable, relieved w/ Food	☐	☐	☐
Alt. Between High/Low Moods	☐	☐	☐
Alt. Between Sluggish/High Energy	☐	☐	☐
High Blood Pressure	☐	☐	☐
Skin Tags at Neck/Armpits	☐	☐	☐
High Cholesterol/Triglycerides	☐	☐	☐
Increased Fat Around Abdomen	☐	☐	☐
Prone to Inflammation/Bursitis	☐	☐	☐

Condition	Current	Past	Chronic
Heart Disease	☐	☐	☐
Seizure Disorder	☐	☐	☐
Recurrent Sinus Infections	☐	☐	☐
Season Allergies	☐	☐	☐
Emotional/Psychiatric Illness	☐	☐	☐
Anxiety/Excessive Stress	☐	☐	☐
Asthma	☐	☐	☐
Chronic Bursitis	☐	☐	☐
Lung/Breathing Problems	☐	☐	☐
Chronic Indigestions	☐	☐	☐
Stomach Ulcers	☐	☐	☐
Intestinal Disease	☐	☐	☐
Skin Problems	☐	☐	☐
Back Pain/Sciatica	☐	☐	☐
Herniated Disk	☐	☐	☐
Headaches/Migraines	☐	☐	☐
Irregular Heart Beat	☐	☐	☐
Blood Clotting	☐	☐	☐
Stroke/Vascular Disease	☐	☐	☐
Kidney Disease	☐	☐	☐
Psoriasis/Eczema	☐	☐	☐
Neck Pain	☐	☐	☐
Cancer	☐	☐	☐

Conditions *continued*	Current	Past	Chronic	Shoulder Problems	☐	☐	☐
Patchy Hair Loss	☐	☐	☐	Osteoarthritis	☐	☐	☐
Unusual Bruising	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Nose Bleeds	☐	☐	☐	**Neuro-Cognitive Psych**	Current	Past	Chronic
Prolonged Bleeding	☐	☐	☐	Sense of Powerlessness	☐	☐	☐
Bleeding Disorders	☐	☐	☐	Mood Swings	☐	☐	☐
Hepatitis/Liver Disease	☐	☐	☐	Loss of Confidence	☐	☐	☐
Menstrual Problems	☐	☐	☐	Decreased Sense of Well-Being	☐	☐	☐
Reproductive Problems	☐	☐	☐	Apathy/Loss of Interest in Life	☐	☐	☐
Prostate Problems	☐	☐	☐	Vision Deteriorating	☐	☐	☐
Tendonitis	☐	☐	☐	Memory Deteriorating	☐	☐	☐
Chest Pains	☐	☐	☐	Balance Deteriorating	☐	☐	☐
Sexual/Libido Problems	☐	☐	☐	Coordination Deteriorating	☐	☐	☐
Chronic Pain	☐	☐	☐	Headaches	☐	☐	☐
Chronic Muscle/Joint Pain	☐	☐	☐	Double Vision	☐	☐	☐
Carpal Tunnel Syndrome	☐	☐	☐	Dizzy/Spinning	☐	☐	☐
Fibromyalgia	☐	☐	☐	Anxiety/Excessive Stress	☐	☐	☐
Diabetes	☐	☐	☐	Loss of Self Esteem	☐	☐	☐
Thyroid Disease	☐	☐	☐	Feeling of Hopelessness	☐	☐	☐
Osteoporosis/Osteopenia	☐	☐	☐	Feeling Defeated	☐	☐	☐

Recent Tests: *Have you had any of these tests in the past 5 years?*

Test	Month/Year	Reason	Result
Chest X-Ray			
EKG			
EGD (Stomach)			
Colonoscopy			
Ultrasound			
CT Scan			
MRI			
Bone Density Scan (Dexa)			
Cholesterol			
Exercise Stress Test			
Other:			

Men

Date of last prostate exam:____________________

Do you perform periodic testicular self-examinations? ☐ YES ☐ NO

Are you concerned with loss of muscle mass, tone or strength? ☐ YES ☐ NO

Has your abdominal girth and weight been increasing? ☐ YES ☐ NO

Have you had any problems with urination (decreased stream/frequent night urination)? ☐ YES ☐ No

Women

Are you pregnant? ☐ YES ☐ NO Date of last menstrual cycle:____________

Date of last pap/pelvic/breast exam:_____________ ☐ Normal ☐ Abnormal

Date of last mammogram______________________ ☐ Normal ☐ Abnormal

Describe any menstrual irregularities:____

How many pregnancies? ______# of children? ______

Were your ovaries removed? ☐ YES ☐ NO Have you had a hysterectomy? ☐ YES ☐ NO

Taking/have taken hormone/oral contraceptives? ☐ YES ☐ NO If yes please list:____________________

Previously had hormone replacement therapy? ☐ YES ☐ NO If yes please list:____________________

Sleep

How much sleep do you get at night (on average)? ______ Approx. time before falling asleep is: ____min

My usual bed time is: __________ am/pm My usual wake up time is: _________ am/pm

My sleep is not restful. ☐ YES ☐ NO

I have difficulty falling asleep. ☐ YES ☐ NO

My partner notices I snore heavily. ☐ YES ☐ NO

My partner notices I stop breathing along w/ my snoring. ☐ YES ☐ NO

I have restless legs that disturb my evening or sleep. ☐ YES ☐ NO

I wake at night hungry or thinking of food. ☐ YES ☐ NO

I have daytime drowsiness or sleepiness. ☐ YES ☐ NO

If I am not active during the day I tend to fall asleep. ☐ YES ☐ NO

I am a nightshift worker. ☐ YES ☐ NO

I have or might have sleep apnea. ☐ YES ☐ NO

Do you wake in the night? ☐ YES ☐ NO If yes how often? _______