EUGENE ENDOCRINOLOGY

Haidee Zamora, MD
Jonathan Bennion, MD
10 Coburg Rd, Suite 201
Eugene, Oregon 97401
Tele: (541) 485-3636
Fax: (541) 344-4305

GENERAL INFORMATION

Name: ______________________________ Language(s) spoken: ______________________

Address: ____

Primary Phone: ______________________ Secondary Phone: _________________________

Date of Birth: ______/ ______/______ Age:_______ Email: ___________________________

REFERRING PROVIDER

Name: ______________________________ Phone Number: _________________________

REASON FOR VISIT

☐ Adrenal issues	☐ Diabetes Type 1	☐ Diabetes Type 2
☐ Diabetes in Pregnancy	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Osteoporosis	☐ PCOS	☐ Prediabetes / Diabetes prevention
☐ Osteopenia	☐ Pituitary	☐ Parathyroid
☐ Thyroid Cancer	☐ Hypogonadism	☐ Other:____________________

ALLERGIES: ☐ No Known Allergies **If you have medication allergies please list below**

MEDICATION	REACTION

SURGICAL HISTORY Please list surgeries you've had, date, and hospital ☐ **None**

SURGERY	DATE	LOCATION

EXAMS YOU'VE HAD DONE:

Eye Exam	Date:	☐	Never
Bone Density	Date:	☐	Never
A1c	Date:	☐	Never

Have you had any hospitalizations, operations, or health events? ______________________________

____

Patient's Name: DOB:

Please list your primary health concerns:____

____

____

MEDICATION RECONCILIATION: (Please **bring all** your medications/supplements when you come in)		
Name:	Strength:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pharmacy that you use:____

OTHER MEDICAL PROVIDERS (Current specialists involved in your care)		
Specialty/Reason	**Name**	**List medical problems**
Ophthalmologist		
Cardiologist		
Pulmonologist		
Gastroenterologist		
Oncologist		
Dermatologist		
Orthopedist		
Urologist		
Gynecologist		
Allergist		
Dental		
Nephrologist		
Psychologist/Psychiatrist		
Primary Care		

Patient’s Name: DOB:

MEDICAL HISTORY Check if now have or have ever had these conditions		
CARDIAC	**GENITOURINARY/ REPRODUCTIVE**	**CANCER**
☐ High blood pressure	☐ Many urine infections	☐ Type:________________
☐ Heart attack	☐ Kidney Stones	
☐ Heart murmur	☐ Infertility	**ENDOCRINE**
☐ Arrhythmia	☐ Erectile Dysfunction	☐ Diabetes
☐ Mitral valve prolapse	Females:	☐ Thyroid
☐ Peripheral vascular disease	☐ Gestational Diabetes	☐ Osteoporosis
☐ Stroke	☐ Irregular periods	☐ High Cholesterol
RESPIRATORY	☐ Hysterectomy	☐ Steroid use
☐ Asthma	Date of last period:______________	☐ Excessive weight gain
☐ Chronic Cough	PAP:_______________	
☐ Bronchitis	Mammogram:_______________	
☐ Emphysema	Pregnancies:________ Births:__________	Females:
MUSCULOSKELETAL	Miscarriages:_________	☐ Polycystic Ovary
☐ Arthritis	**HEMATOLOGIC**	Syndrome
☐ Other: ______________	☐ Easy bleeding ☐ Easy bruising	☐ Unwanted facial or
GASTROINTESTINAL	☐ History of blood clot	Body hair
☐ Ulcers	**NEUROLOGIC**	
☐ Irritable Bowel Syndrome	☐ Spine / back injury	
☐ Constipation	☐ Seizures	
☐ Diverticulitis	☐ Migraines	
☐ Crohns / Colitis	☐ Recurrent headaches	

FAMILY HISTORY - are you adopted? ☐ Yes ☐ No

Have any of your family members ever had any of the following? (Please cross out any family listed below that doesn’t apply to you…e.g. If you don’t have a brother, just cross out Brother.)

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Rheumatoid Arthritis								
Osteoporosis								
Asthma								
Cancer								
Diabetes								
Heart Failure								
High Cholesterol								
Hypertension								
Migraines								
Rashes/Skin Problems								
Seizures								
Stroke								
Thyroid Disease								

Patient's Name: DOB:

REVIEW OF SYSTEMS - please check if you are currently experiencing any of the following
If none of the below symptoms are present, please mark here ☐ NO CURRENT SYMPTOMS

GENERAL WELL-BEING:		**BREAST:**		**EARS, NOSE, THROAT, MOUTH:**	
☐	Weight Loss	☐	Pain	☐	Ulcers
☐	Weight Gain	☐	Gynecomastia	☐	Hoarseness
☐	Fever	☐	Nipple Discharge	☐	Sinus Pain
☐	Fatigue	☐	Breast Lump	☐	Hearing Problems
☐	Excessive Thirst	☐	Rash	☐	Ringing in the Ears
☐	Excessive Hunger			☐	Difficulty Swallowing
☐	Problems Sleeping	**CARDIOVASCULAR:**			
☐	Heat Intolerance	☐	Shortness of Breath	**EYES:**	
☐	Cold Intolerance	☐	Chest Pain	☐	Vision Changes
		☐	Palpitations	☐	Excessive Tearing
BLOOD SYSTEM:		☐	Swelling	☐	Eye Discharge
☐	Bleed Easily			**MUSCULOSKELETAL:**	
☐	Bruise Easily	**RESPIRATORY:**		☐	Weakness
☐	Enlarged Lymph Nodes	☐	Coughing	☐	Muscles Pain
		☐	Coughing up Blood	☐	Joint Pain
GASTROINTESTINAL:		☐	Wheezing		
☐	Excessive Bloating / Gas			**URINARY / GYNECOLOGIC:**	
☐	Diarrhea	**NEUROLOGICAL:**		☐	Blood in Urine
☐	Constipation	☐	Dizziness	☐	Painful Urination
☐	Nausea	☐	Headache	☐	Urgency
☐	Vomiting	☐	Near passing out	☐	Frequency
☐	Bloody Stools	☐	Numbness	☐	Pain with Intercourse
☐	Pain with Bowel Movement	☐	Difficulty Walking	Women:	☐ Irregular Periods
☐	Abdominal Pain	☐	Memory Problems		☐ Vaginal Discharge
PSYCHOLOGICAL:					
☐	Severe Agitation	**SLEEP DISTURBANCE:**		**SKIN:**	
☐	Depression	☐	Difficulty Falling Asleep	☐	Acne
☐	Severe Mood Swings	☐	Waking up Frequently at night	☐	Hair Loss
☐	Anxiety	☐	Excessive Sleepiness during	☐	Hair Growth
☐	Confusion	the day		☐	Dryness
				☐	Rash

Patient's Name: DOB:

SOCIAL HISTORY:

Are you currently married?	☐	Yes	☐	No		
with a partner	☐	Yes	☐	No		
Do you smoke?	☐	Yes	☐	No	☐	Never
If yes: How many packs a day?________	For how long? ________					
If quit: When did you quit? ____________						
When you did smoke, how many packs per day? ___________ For how long?__________						
Do you exercise?	☐	Yes	☐	No		
If yes: Aerobic activity?	☐	Yes	☐	No	Times per week?___________	
Strength training?	☐	Yes	☐	No	Times per week?___________	
Yoga / Stretching?	☐	Yes	☐	No	Times per week?___________	
Do you drink alcohol?	☐	Yes	☐	No	_______ drinks per day	
Do you consume caffeine?	☐	Yes	☐	No	_______ drinks per day	
Do you currently use recreational drugs?	☐	Yes	☐	No		
Have you used recreational drugs in the past?	☐	Yes	☐	No		