PACIFIC PITUITARY DISORDERS CENTER

AT PACIFIC NEUROSCIENCE INSTITUTE℠

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Your phone numbers: *Home:* _____ *Cell:* _____ E-Mail address: _____

Emergency Contact Person: _____ Phone number: _____

I came to see Dr. Kelly/ Barkhoudarian by: _____ Referral from another physician (name): _____

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

_____ My own research (explain): _____

_____ Other: _____

Prior to seeing Dr. Kelly/ Barkhoudarian I went online and reviewed the website ___ Yes ___No

Why are you seeing Dr. Kelly/ Barkhoudarian? _____

What are your symptoms related to this problem?

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

Have you been diagnosed with other medical problems?

- ☐ High blood pressure _____
- ☐ High cholesterol/ Hyperlipidemia _____
- ☐ Lung disease/ Asthma _____
- ☐ Gastro-intestinal problems _____
- ☐ Depression _____
- ☐ Seizures _____
- ☐ Pituitary/Hormone disorders _____
- ☐ Cancer – type? _____
- ☐ Heart disease (heart attack) _____
- ☐ Diabetes _____
- ☐ Thyroid _____
- ☐ Kidney Disease/ dialysis _____
- ☐ Alzheimer's/Parkinson's disease _____
- ☐ Stroke _____
- ☐ Brain tumor (benign or malignant) _____
- ☐ 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. Kelly/ Barkhoudarian? Please provide phone and fax numbers.

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

MEDICATIONS

Are you taking any medications? Yes ☐ No ☐ If **YES** please list below:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES: Do you have any allergies to medications? Yes ☐ No ☐ If **YES** please list below and describe reaction to medication:

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

Clinic address: 2121 Santa Monica Boulevard, Santa Monica, CA 90404
Mailing address & Administrative offices: 2020 Santa Monica Blvd CA 90404
Phone 310-582-7450 | Fax 310-582-7495 | www.pacificpituitary.org

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SOCIAL HISTORY

☐ Married ☐ Single ☐ Children? Number: _____

Are you currently employed? Yes ☐ No ☐ Current position? _____

Are you disabled? _____ If YES, 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 the box:

☐ Heart disease (heart attack) _____

☐ Lung disease/ Asthma _____

☐ Diabetes _____

☐ Depression _____

☐ Seizures _____

☐ Cancer – type? _____

☐ High blood pressure _____

☐ Kidney Disease/ dialysis _____

☐ Thyroid problem _____

☐ Alzheimer's/Parkinson's disease _____

☐ Stroke _____

☐ Other issues _____

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

General

Y	N	Don't Know	
☐	☐	☐	Fever, chills, sweats
☐	☐	☐	Loss of appetite, weight loss

Eyes

Y	N	Don't Know	
☐	☐	☐	Eyes irritation/infection
☐	☐	☐	Glaucoma/cataract/eye surgery
☐	☐	☐	Wear glasses/contacts

ENT/Mouth

Y	N	Don't Know	
☐	☐	☐	Earache/ringing
☐	☐	☐	Sinusitis, runny nose, allergies
☐	☐	☐	Oral ulcerations

Respiratory

Y	N	Don't Know	
☐	☐	☐	Asthma, emphysema/bronchitis
☐	☐	☐	Cough
☐	☐	☐	Recent chest x-ray
☐	☐	☐	Tuberculosis

Cardiovascular

Y	N	Don't Know	
☐	☐	☐	Short of breath
☐	☐	☐	Irregular heartbeat

Psychiatric

Y	N	Don't Know	
☐	☐	☐	Depression
☐	☐	☐	Anxiety disorder

Gastrointestinal

Y	N	Don't Know	
☐	☐	☐	Nausea/vomiting
☐	☐	☐	Diarrhea/constipation/bloody stools
☐	☐	☐	Heartburn/indigestion/reflux disease
☐	☐	☐	Polyps/colonoscopy

Genitournary

Y	N	Don't Know	
☐	☐	☐	Increased urination
☐	☐	☐	Diarrhea/constipation/bloody stools

Musculoskeletal

Y	N	Don't Know	
☐	☐	☐	Leg cramps
☐	☐	☐	Arthritis/arthralgias/gout
☐	☐	☐	Soft tissue/bony trauma
☐	☐	☐	Congenital deformity

Skin

Y	N	Don't Know	
☐	☐	☐	Leg ulcers/discoloration of feet/legs
☐	☐	☐	Bruising/bleeding tendencies
☐	☐	☐	Acne

Reproductive

Y	N	Don't Know	
☐	☐	☐	Normal periods
☐	☐	☐	Absent periods
☐	☐	☐	Irregular periods
☐	☐	☐	Post-menopausal
☐	☐	☐	Pre-menopausal
☐	☐	☐	Hysterectomy

Please sign below:

Patient Signature: _____

Affix Patient Label Here

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