DIABETES ASSOCIATES MEDICAL GROUP

PATIENT NAME: **DOB:**

SYMPTOMS-Please circle or underline the correct answer

Any Acne, abnormal male hair growth pattern in a female, fluid retention, exaggerated moods, excessive aggression, recession of scalp hair, deepening of the voice, enlargement of the clitoris, increased libido, hot flashes, night sweats, vaginal dryness, low libido, inability to achieve orgasm, shrinking of breasts, vaginal yeast infections, mood swings, painful intercourse, lack of menstruation, infrequent menses, more frequent menses, dry skin, breast swelling, breast tenderness, premenstrual moods swings, food cravings, menstrual cramps, drowsiness, difficulty concentrating, depression, unexplained fatigue, oily skin, excessive sweating, increase in ring size, increase in shoe size, increase in head size, unexplained chronic headaches, milky discharge from breasts, excessive stimulation of the nipple, failure to lactate following delivery of a baby, lack or decrease of ability to smell, visual impairment, loss of visual field, tunnel vision, unexplained recurrent nausea and vomiting, abdominal pain, low blood pressure, low blood sugar in non-diabetic, easy bruising, thinning of the skin, osteoporosis, slow wound healing, impotence (for males), chronic diarrhea, difficult to treat hypertension, difficult to treat stomach ulcer, abnormal skin pigmentation, abnormal stretch marks, tremors, excessive urination, previous brain trauma, severe head injury, concussion, loss of consciousness, brain tumor, previous brain radiation treatment, previous brain surgery, previous chemotherapy, inability to perceive smells?.

Does a family member have infertility----------Yes/no
Does a family member have inability to perceive smells----------Yes/no
How much weight have you gain in the past 1 year ----------
How much weight have you lost in the past 1 year? ----------
What is your target body weight----------
Do you find it difficult to lose weight? ---------- Yes/no
Are you on an extreme weight loss diet? ---------- Yes/no
Are you anorexic or bulimic----------Yes/no
What has been your highest body weight ever? **----------**
Are you under undue mental or emotional stress? ----------Yes/no
Do you exercise intensely or perform prolonged physical exertion----------Yes/no
Do you participate in organized sports? ----------Yes/no
Please state your ancestral race if you can----------
Are you of Jewish decent, Ashkanazi Jew, Moroccan Jew, Yupik Eskimo of southwestern Alaska ----------

For females
Age at your very first menses----------
How frequent are your menses ----------
How many menses do you typically have in a year ----------
Approximately how many menses did you have in the last 12 months?**----------**

Are your menses fairly regular----------Yes/no
Are your menses irregular----------Yes/no
How many years or months have you had irregular menstrual periods ----------
Were your menses irregular from the time of your first menses----------Yes/no
Does your sister, mother, or aunt have irregular menstrual periods ----------Yes/no
Have you been diagnosed with Polycystic ovarian syndrome----------Yes/no
Do you have any difficulty getting pregnant----------Yes/no
How long have you been trying to get pregnant ----------
# of pregnancies----------# of miscarriages----------# of deliveries----------
For birth control pill users when did you start and when did you stop the pill----------
Date of your last menstrual period----------
Age at menopause----------
What has been your highest nonpregnant body weight ever? ----------
List your medications:

What is your pharmacy---------- phone number----------?
fax number----------?
Are you on a mail order prescription plan----------?