Adrenal Intake Questionnaire

Patient Name: _____ Date of Birth: _____

Self-referral or referred by: _____ Reason for referral: _____

Prior endocrinologist (if any): _____

Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

1) When were you told about your adrenal problem? _____
2) How was it found? _____
3) Have you had a CT or MRI of your abdomen done? Yes or No. If yes, when? Please bring a CD with images and the report with you. _____
4) What treatments have you had related to this? _____

   _____
5) Have you had adrenal surgery? Yes or No. If yes, when and where was it done?

   _____
6) Are you having any symptoms associated with your adrenal problem? Yes or No. If yes, explain:

   _____
7) Are you taking or have you taken any of these medicines in the last **2 months**?

Medications	Yes	No	Which one?
Herbal medications	___	___	_____
Amitriptyline, imipramine, doxepin	___	___	_____
Flexeril (Cyclobenzaprine)	___	___	_____
Decongestants	___	___	_____
Buspirone	___	___	_____
Prochlorperazine (for schizophrenia)	___	___	_____
Hormones (estrogen or OCPs)	___	___	_____
Steroids (Inhaled, oral, nasal, injectable or topical)	___	___	_____
Opioids (morphine, methadone, etc)	___	___	_____
Clonidine, levodopa	___	___	_____
Benzodiazepines (Valium, Ativan, Xanax, Clonopin, etc)	___	___	_____

8) Do you have any of these medical problems specifically?

Medical History	Yes	No	Year or diagnosis and details
Thyroid disease	___	___	_____
Parathyroid disease	___	___	_____
Diabetes mellitus	___	___	_____
Adrenal disease	___	___	_____
Osteoporosis/bone disease	___	___	_____
Liver disease	___	___	_____
Renal disease	___	___	_____

9) Does anyone in your family have a history of adrenal, parathyroid or thyroid problems? Yes or No. If yes, please describe:

_____

10) Do you have a history of amphetamine or cocaine use? ☐ Yes or ☐ No

11) Do you have a history of alcohol use? ____Yes or ____No

Symptom Review (any in the last 1 month):

Fatigue ____ fever____ weight gain ____ weight loss ____

Headaches ____ brain fog ____ changes in features of your face____ facial flushing____

Vision changes ____ Bumping into things____

Dry skin ____ itchy skin ____ stretch marks on abdomen____ easy bruising____

Chest pain____ shortness of breath ____ leg swelling ____ palpitations ____

Abdominal pain____ Nausea ____ vomiting ____ diarrhea ____ constipation ____

For women: Irregular periods____ milky breast discharge ____ low sex drive____

For men: Erectile dysfunction____ milky breast discharge ____ or low sex drive____

Anxiety ____ depression ____

Intolerance to cold ____ intolerance to heat____ hair loss ____

Hand tremor ____ or shaking____

Weakness of arms or legs ____ joint pain ____ increase in ring or shoe size____

None of the above____