THE SCHUSTER CLINIC FOR ENDOCRINE AND METABOLIC DISORDERS
LAWRENCE D. SCHUSTER, M.D., PH.D., F.A.C.P., F.A.C.E
Central Office
255 PINEHURST BLDG, 4999 FRANCE AVE S., MINNEAPOLIS MN 55410

Patient Name _____ Date _____

PHYSICIAN INFORMATION

REFERRING PHYSICIAN

_____

Name and Address of Referring Physician (this must be filled in)

PRIMARY PHYSICIAN

_____

Name and Address of Family Physician, Gynecologist or Internist (please specify)

SPECIALTY PHYSICIAN

_____

Name and Address of Specialist

PRESENT MEDICATIONS

Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started

PAST MEDICATIONS (WITHIN PAST YEAR)

Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started
Name of Drug	Dose	Frequency	Date started

PAST HOSPITALIZATIONS

Reason for Admission	Diagnosis	Date of Admission and Discharge	Treating Physician
Reason for Admission	Diagnosis	Date of Admission and Discharge	Treating Physician
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PATIENT HISTORY FORM

Please place an "X" in the appropriate box. Write a **BRIEF** explanation on all "yes" answers that you feel are of **MAJOR** significance to your health status and indicate how long each symptom has been present.

GENERAL HEALTH

	NO	YES			NO	YES	
1.	[ ]	[ ]	Decrease in general health _____	22.	[ ]	[ ]	Abnormal shaving history _____
2.	[ ]	[ ]	Decrease in energy level _____	23.	[ ]	[ ]	Changes in figernails _____
3.	[ ]	[ ]	Decrease in strength _____	24.	[ ]	[ ]	Changes in overall appearance _____
4.	[ ]	[ ]	Chills or fever _____	25.	[ ]	[ ]	Excessive sweating _____
5.	[ ]	[ ]	Night sweats _____	26.	[ ]	[ ]	Facial flushing _____
6.	[ ]	[ ]	Insomnia _____	**LYMPH NODES**			
7.	[ ]	[ ]	Decrease in weight (# lbs) _____	27.	[ ]	[ ]	Enlarged glands in the neck _____
			Length of time weight was lost _____	28.	[ ]	[ ]	Enlarged glands in the armpit _____
8.	[ ]	[ ]	Increase in weight (# lbs) _____	29.	[ ]	[ ]	Enlarged glands in the groin _____
			Length of time weight gained _____	**MUSCULOSKELETAL**			
9.	[ ]	[ ]	History of Rheumatic Fever _____	30.	[ ]	[ ]	Generalized joint or muscle pain _____
10.	[ ]	[ ]	History of Tuberculosis _____	31.	[ ]	[ ]	Joint or muscle stiffness _____
11.	[ ]	[ ]	History of Gonorrhea _____	32.	[ ]	[ ]	Swelling of joints _____
12.	[ ]	[ ]	History of Syphillis _____	33.	[ ]	[ ]	Arthritis _____
13.	[ ]	[ ]	History of HIV or AIDS _____	34.	[ ]	[ ]	History of Gout _____
	SKIN, HAIR AND NAILS						
14.	[ ]	[ ]	Changes in skin color or texture _____	35.	[ ]	[ ]	Change in hand size _____
15.	[ ]	[ ]	Dry skin _____	36.	[ ]	[ ]	Change in feet size _____

16. [ ] [ ] Moist skin _____

17. [ ] [ ] Change in hair distribution _____

18. [ ] [ ] Course hair texture _____

19. [ ] [ ] Hair loss _____

20. [ ] [ ] Hair gain _____

37. [ ] [ ] Change in jaw size _____

BLOOD DISORDERS

38. [ ] [ ] History of anemia _____

39. [ ] [ ] Bleeding disorders _____

40. [ ] [ ] Bruise easily _____

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ENDOCRINE & METABOLISM

	NO	YES		NO	YES
41.	[ ]	[ ]	History of pituitary disease _____		
42.	[ ]	[ ]	History of thyroid disease _____		
3.	[ ]	[ ]	Hisotry of goiter _____		
44.	[ ]	[ ]	Cold intolerance _____		
45.	[ ]	[ ]	Heat intolerance _____		
46.	[ ]	[ ]	Currently taking or have ever taken Thyroid medication _____		
47.	[ ]	[ ]	History of parathyroid disease _____		
48.	[ ]	[ ]	History of tetany (muscle spasms) _____		

ADRENAL GLANDS

49. [ ] [ ] History of adrenal gland disorder _____

50. [ ] [ ] Salt craving _____

51. [ ] [ ] Changes in taste _____

52. [ ] [ ] History of prolonged recovery from the flu _____

53. [ ] [ ] History of cortisone (steroid) therapy _____

GONADS

54. [ ] [ ] History of ovarian disease _____

55. [ ] [ ] History of testicular disorders _____

IMMUNOLOGY

63. [ ] [ ] Allergies _____

64. [ ] [ ] Asthma _____

65. [ ] [ ] Hay fever _____

66. [ ] [ ] Medication allergies _____ _____ _____

HEAD

67. [ ] [ ] Headaches _____

68. [ ] [ ] Migraines _____

69. [ ] [ ] Dizziness _____

70. [ ] [ ] Fainting _____

71. [ ] [ ] Blackouts _____

72. [ ] [ ] Seizures _____

73. [ ] [ ] Changes in head or hat size _____

EYES

74. [ ] [ ] Difficulty seeing _____

75. [ ] [ ] Double vision _____

76. [ ] [ ] Change in degree of eye protrusion _____

77. [ ] [ ] History of glaucoma

PANCREAS

56. [ ] [ ] History of pancreatic disease _____
57. [ ] [ ] Excessive hunger _____
58. [ ] [ ] Excessive thirst _____
59. [ ] [] Excessive urination _____
60. [ ] [ ] History of diabetes mellitus _____
61. [ ] [ ] History of diabetes insipidus _____
62. [ ] [ ] History of special diet therapy _____

EARS

78. [ ] [ ] Difficulty hearing _____
79. [ ] [ ] Ringing in the ears _____

NOSE

80. [ ] [ ] Loss of smell _____
81. [ ] [ ] Absemce of smell _____

THROAT AND MOUTH

82. [ ] [ ] Difficult or painful swallowing _____

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Patient name _____ Date _____

	NO	YES			NO	YES	
83.	[ ]	[ ]	Difficulty speaking _____	99.	[ ]	[ ]	History of lung disease _____
84.	[ ]	[ ]	Change in pitch of voice _____	100.	[ ]	[ ]	Chest xray, date, results and location of most recent xray _____
85.	[ ]	[ ]	Hoarseness of voice _____				
86.	[ ]	[ ]	Changes in tongue size _____				**CARDIOVASCULAR**
				101.	[ ]	[ ]	Chest pain with exertion _____
			NECK	102.	[ ]	[ ]	Irregular heart beat _____
87.	[ ]	[ ]	Swelling, mass or lump in neck _____	103.	[ ]	[ ]	Rapid heart beat _____
88.	[ ]	[ ]	History of goiter _____	104.	[ ]	[ ]	Palpitations/awareneness of heart beat _____
89.	[ ]	[ ]	History of radiation treatment to:				
	[ ]	[ ]	the neck _____	105.	[ ]	[ ]	Heart murmur _____
	[ ]	[ ]	the face _____	106.	[ ]	[ ]	History of heart disease _____
	[ ]	[ ]	the scalp _____	107.	[ ]	[ ]	High blood pressure _____
	[ ]	[ ]	Other _____	108.	[ ]	[ ]	Poor circulation to extremities _____
			FEMALE BREAST	109.	[ ]	[ ]	Swollen ankles _____
90.	[ ]	[ ]	Breast discharge _____	110.	[ ]	[ ]	Urination at night/# of times _____
91.	[ ]	[ ]	Lumps in breast _____	111.	[ ]	[ ]	EKG, date, results and location
			MALE BREAST				
92.	[ ]	[ ]	Breast enlargement _____				
			RESPIRATORY				
93.	[ ]	[ ]	Difficult or painful breathing				

_____

94. [ ] [ ] Shortnesss of breath when walking

_____

[ ] [ ] How many blocks can you walk?

_____

95. [ ] [ ] Shortness of breath climbing stairs

_____

[ ] [ ] How many stairs can you climb?

_____

96. [ ] [ ] Sleep propped-up in bed

_____

97. [ ] [ ] Chronic dry cough

_____

98. [ ] [ ] Chronic cough that brings up blood or Sputum _____

of most recent EKG

_____

GASTROINTESTINAL

112. [ ] [ ] Appetite poor

_____

113. [ ] [ ] Nausea

_____

114. [ ] [ ] Vomiting

_____

115. [ ] [ ] Constipation

_____

116. [ ] [ ] Diarrhea

_____

117. [ ] [ ] Bloody stools

_____

118. [ ] [ ] Black tarry stools

_____

119. [ ] [ ] History of ulcer

_____

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Patient name _____ Date _____

	NO	YES			NO	YES	
120.	[ ]	[ ]	History of hepatitis _____	141.	[ ]	[ ]	History of venereal disease _____
121.	[ ]	[ ]	History of an eating disorder _____	142.	[ ]	[ ]	Currently taking birth control pills _____
122.	[ ]	[ ]	History of treatment for obesity _____	143.	[ ]	[ ]	Currently taking estrogen/Premarin _____ Pills_____ Cream _____
GENITO-URINARY							
123.	[ ]	[ ]	Difficult or painful urination _____	144.	[ ]	[ ]	Date of last pelvic exam _____
124.	[ ]	[ ]	Difficulty starting urination _____	145.	[ ]	[ ]	Last pap smear _____
125	[ ]	[ ]	Difficulty stopping urination _____	146.	[ ]	[ ]	History of pregnancies _____
126.	[ ]	[ ]	History of blood or pus in urine _____	147.	[ ]	[ ]	History of abortions _____
127.	[ ]	[ ]	History of kidney stones _____	148.	[ ]	[ ]	History of births _____
128.	[ ]	[ ]	History of kidney disease _____	149.	[ ]	[ ]	History of pregnancy complications _____
MALE REPRODUCTION				150.	[ ]	[ ]	Excessive bleeding associated with Labor and delivery _____
129.	[ ]	[ ]	Difficulty achieving an erection _____				
130.	[ ]	[ ]	Decrease in sex drive	151.	[ ]	[ ]	Severe drop in blood pressure (shock)

_____

131. [ ] [ ] Changes in size of testicles

_____

132. [ ] [ ] Hair loss under arms

_____

FEMALE REPRODUCTION

133. [ ] [ ] Age of first menstruation

_____

134. [ ] [ ] Regular menstrual cycles

_____

How regular? _____

135. [ ] [ ] Frequent or infrequent cycles

_____

136. [ ] [ ] Lengh of menstrual flow

_____

137. [ ] [ ] Description and number of pads Used during menstrual cycle

Heavy ___ Regular ___ Light __

138. [ ] [ ] Age of meopause (if present)

_____

139. [ ] [ ] Hot flashes

_____

140. [ ] [ ] History of pelvic infection

_____

associated with childbirth

_____

FEMALE INFERTILITY (IF PRESENT)

152. [ ] [ ] Frequency of intercourse

_____

153. [ ] [ ] Position during intercourse

_____

154. [ ] [ ] Length of time before rising after intercourse

_____

155. [ ] [ ] Use of douches

_____

156. [ ] [ ] Use of lubrications or jellies

_____

NEUROLOGICAL

157. [ ] [ ] Decrease in strength

_____

159. [ ] [ ] Hand tremor

_____

160. [ ] [ ] Numbness or tingling in hands or feet (Carpal Tunnel)

_____

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LDS

Patient name _____ Date _____

	NO	YES	
161.	[ ]	[ ]	Burning sensation in feet
162.	[ ]	[ ]	Leg pains
163.	[ ]	[ ]	Loss of sensation

PSYCHIATRIC HISTORY

164. [ ] [ ] Nervousness

_____

165. [ ] [ ] Anxiousness

_____

166. [ ] [ ] Easily irritable

_____

167. [ ] [ ] Depression

_____

168. [ ] [ ] History of other psychiatric

	NO	YES	
180.	[ ]	[ ]	Number of your children/ages

_____

_____

_____

FAMILY HISTORY

Write the family member affected by the illness or disease

181. [ ] [ ] Thyroid disease

_____

182. [ ] [ ] History of goiter

_____

183. [ ] [ ] Diabetes Mellitus

_____

184. [ ] [ ] Heart Disease

_____

185. [ ] [ ] High blood pressure

_____

Disease

SOCIAL HISTORY

169. [ ] [ ] Past history of smoking
Amount_____

170. [ ] [ ] Currently smoke
Amount_____

171. [ ] [ ] Drink alcohol
Amount_____

172. [ ] [ ] History of drug abuse
_____

173. [ ] [ ] Currently live along
_____

174. [ ] [ ] Currently live with:
_____

175. [ ] [ ] Present job
_____

176. [ ] [ ] Previous jobs
_____

177. [ ] [ ] One or both parents living
Mother's age_____
Father's age_____

178. [ ] [ ] One or both parents deceased
Mother's age at death_____
Father's age at death_____

179. [ ] [ ] Number of brothers and sisters
_____

186. [ ] [ ] Stroke
_____

187. [ ] [ ] Cancer
_____

188. [ ] [ ] Gout
_____

189. [ ] [ ] Kidney disease
_____

190. [ ] [ ] Other
_____
_____
_____
_____
_____