Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Patient's Name: _____ Today's Date: _____

Patient's Date of Birth: _____ Height: _____ Weight: _____

Who referred you to us? _____

Please circle one:

YES	NO	1. Have you lost your appetite?
YES	NO	2. Have you lost weight?
YES	NO	3. Are you constipated?
YES	NO	4. Has your constipation increased in the past year?
YES	NO	5. Do you suffer from nausea?
YES	NO	6. Do you suffer from heartburn?
YES	NO	7. Are your joints painful?
YES	NO	8. Are your joints ever swollen?
YES	NO	9. Do you suffer with painful bones?
YES	NO	10. Have you ever broken more than one bone?
YES	NO	11. Do you suffer from low back pain?
YES	NO	12. Do you get up more often during the night to urinate?
YES	NO	13. Do you urinate more frequently?
YES	NO	14. Have you ever had blood in your urine?
YES	NO	15. Have you ever had kidney stone?
YES	NO	16. Have you ever had gout?
YES	NO	17. Do you have increased thirst?
YES	NO	18. Do your fatigued all the time?
YES	NO	19. Are you weaker than you were one or two years ago?
YES	NO	20. Do you suffer from depression?
YES	NO	21. Are you having problems remembering recent events?
YES	NO	22. Have you ever had a duodenal ulcer?
YES	NO	23. Have you ever had pancreatitis?
YES	NO	24. Have you ever had a gastric (stomach) ulcer?
YES	NO	25. Do you bruise easily?
YES	NO	26. Do you itch?
YES	NO	27. Do you have hypertension (high blood pressure)?
YES	NO	28. Have you ever had radiation treatments?
YES	NO	29. Has anyone in your family had high blood calcium levels?
YES	NO	30. Has anyone in your family had a tumor of the pancreas?
YES	NO	31. Has anyone in your family had pituitary tumor?
YES	NO	32. Do you smoke?
YES	NO	33. Have you been hoarse when you didn't have a cold?
YES	NO	34. Do you have trouble swallowing?
YES	NO	35. Have you had trouble with your eyes in the past two years?

YES NO 36. Do you have pain in your neck?
YES NO 37. Do you feel lump in your neck?
YES NO 38. Does your heart ever beat very rapidly?
YES NO 39. Have you ever had a heart murmur?
YES NO 40. Do you take vitamins or other nutritional supplements?
YES NO 41. Do you take calcium supplements?
YES NO 42. Are you currently taking any medications? If so, please list them below.

_____

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