Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

UNIT NUMBER:
PT. NAME:
DOB:

REFERRING MD:
ATTENDING MD:
DATE OF SERVICE:

1. Why are you here today? What are your symptoms or problems?

_____

_____

_____

2. Have you been treated for this problem before? __ No __ Yes If yes, date of last treatment? _____

   Where were you treated? __ NewYork-Presbyterian/Weill Cornell __ NewYork-Presbyterian/Columbia __ Other

3. Do you have any other health problems? __ No __ Yes If yes, please describe below:

_____

_____

4. What medicines do you take regularly? Include over-the-counter medicines, like aspirin, Tylenol, etc.

_____

_____

5. Have you ever been exposed to x-rays or other types of radiation? __ No __ Yes

   If yes, for what condition(s) were you exposed? __ Acne or skin problem __ Dental x-rays __ Enlarged thymus

   __ Tonsil or adenoid problem __ Other _____

6. Have you ever been treated for thyroid problems? __ No __ Yes If yes, please describe problem:

_____

_____

7. Have you ever been treated for a growth or tumor in your thyroid gland? __ No __ Yes

   If yes, was it cancer? __ No __ Yes

   What type of treatment did you receive for this growth? (check all that apply)

   __ Iodine-^{131} __ Surgery __ Other _____ Date of treatment _____

   Have you ever taken thyroid hormone replacement? __ No __ Yes If yes, what dose? _____

   Have you ever taken anti-thyroid hormone medications? __ No __ Yes If yes, what dose? _____

8. Have you ever been treated for any of the following endocrine problems? (check all that apply)

Adrenal tumor	__ No	__ Yes	Pituitary tumor	__ No	__ Yes
Cushing's disease	__ No	__ Yes	Zollinger Ellison syndrome	__ No	__ Yes
Hyperparathyroidism	__ No	__ Yes	Multiple Endocrine Neoplasia (MEN)	__ No	__ Yes
Diabetes	__ No	__ Yes			

9. Has anyone in your family ever been treated for one of these conditions? (check all that apply)

Adrenal tumor	__ No	__ Yes	Pituitary tumor	__ No	__ Yes
Cushing's disease	__ No	__ Yes	Zollinger Ellison syndrome	__ No	__ Yes
Hyperparathyroidism	__ No	__ Yes	Multiple Endocrine Neoplasia (MEN)	__ No	__ Yes
Diabetes	__ No	__ Yes	Thyroid tumor	__ No	__ Yes

If you answered "yes" to any condition in question 9, which family member(s) have been treated? (Check all that apply.)

_ Mother	_ Father
_ Sister	_ Brother
_ Daughter	_ Son
_ Grandmother	_ Grandfather
_ Aunt	_ Uncle
_ Cousin	_ In-law
_ Other	