



Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Patient's Name: _____ Today' Date: _____

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

Who referred you to us? _____

Please circle one:

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|-----|----|--|
| 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 hair loss? |
| YES | NO | 7. If yes, has your hair loss become worse recently? |
| YES | NO | 8. Do you suffer from heartburn? |
| YES | NO | 9. Are your joints painful? |
| YES | NO | 10. Are your joints ever swollen? |
| YES | NO | 11. Do you suffer with painful bones? |
| YES | NO | 12. Have you ever broken more than one bone? |
| YES | NO | 13. Do you suffer from low back pain? |
| YES | NO | 14. Do you get up more often during the night to urinate? |
| YES | NO | 15. Do you urinate more frequently? |
| YES | NO | 16. Have you ever had blood in your urine? |
| YES | NO | 17. Have you ever had a kidney stone? |
| YES | NO | 18. Have you ever had gout? |
| YES | NO | 19. Do you have increased thirst? |
| YES | NO | 20. Are you fatigued all the time? |
| YES | NO | 21. Are you weaker than you were 1 or 2 years ago? |
| YES | NO | 22. Do you suffer from depression? |
| YES | NO | 23. Do you have problems remembering recent events? |
| YES | NO | 24. Have you ever had a duodenal ulcer? |
| YES | NO | 25. Have you ever had pancreatitis? |
| YES | NO | 26. Have you ever had a gastric (stomach) ulcer? |
| YES | NO | 27. Do you bruise easily? |
| YES | NO | 28. Do you itch? |
| YES | NO | 29. Do you have high blood pressure? |
| YES | NO | 30. Have you ever had radiation treatments? |
| YES | NO | 31. Has anyone in your family had high blood calcium levels? |
| YES | NO | 32. Has anyone in your family had a tumor in the pancreas? |
| YES | NO | 33. Has anyone in your family had a pituitary tumor? |

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| YES | NO | 34. Do you smoke? |
| YES | NO | 35. Have you been hoarse when you didn't have a cold? |
| YES | NO | 36. Do you have trouble swallowing? |
| YES | NO | 37. Have you had trouble with your eyes in the past two years? |
| YES | NO | 38. Do you have a pain in your neck? |
| YES | NO | 39. Do you feel a lump in your neck? |
| YES | NO | 40. Does your heart ever beat very rapidly? |
| YES | NO | 41. Have you ever had a heart murmur? |
| YES | NO | 42. Do you take vitamins or other nutritional supplements? |
| YES | NO | 43. Do you take calcium supplements? |
| YES | NO | 44. Are you currently taking any medications? If so, please list them below: |
