UCLA Health

Endocrine Surgery Consultation Checklist

☐ Complete the Surgical Consultation Health History Form in advance, if possible, and bring it with you.

☐ Arrange to have all medical records that are relevant to your current problem faxed to us at (310) 267-8632, if they are from outside of the UCLA Health System. Important documents include:

- Past operation reports
- Pathology/biopsy reports
- Radiology reports (scan results)
- Doctor's notes
- Copies of all medical images on a CD (CAT scans, MRIs, nuclear medicine scans)
- If you have had a biopsy or previous thyroid or parathyroid surgery outside of UCLA, we will need our pathologists to review your tissue specimens (slides).

☐ If you need additional imaging or testing, please advise us in advance so that we may schedule these on the same day as the surgical consultation for your convenience.

☐ Please bring the following items with you to your consultation:

- The Surgical Consultation Health History Form.
- A list of questions that you would like to ask the doctor (doing this in advance makes it less likely that you will forget something).
- Contact information for your referring physician(s) and primary care doctor.
- List of your current medications.
- We highly recommend that you bring one adult family member or a trusted friend with you to your appointment.

☐ What to expect during your visit:

- You will have a consultation with your surgeon. As this is a university teaching center, you may also meet a resident physician or medical student in addition to your surgeon.
- Most patients will have an ultrasound performed by their surgeon (there is no charge). This is a painless scan that will help us determine the nature of the problem and how to treat it.
- You will have the opportunity to ask questions.
- If surgery is needed, we will schedule a date at the end of the visit.

UCLA Health

ENDOCRINE CENTER

SURGICAL CONSULTATION
HEALTH HISTORY FORM

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**	**AGE:**	
Home address *(Street):*			**Home phone:**		
(City/State/Zip):			**Mobile phone:**		
Email:			**Fax:**		

Referring MD:
Specialty:
Address:

Cite/State/Zip:
Phone:
Fax:

Primary/Other MD:
Specialty:
Address:

Cite/State/Zip:
Phone:
Fax:

Nearest Relative/Emergency Contact:
Relation to you:
Home phone:
Work phone:
Mobile phone:

MEDICAL HISTORY

Have you ever had any of the following conditions?

DISEASE	YES	NO	DATE	DISEASE	YES	NO	DATE
Angina				Stomach ulcer			
Heart attack				Liver disease/cirrhosis			
Heart failure				Kidney disease/dialysis			
Heart murmur				Kidney stones			
High blood pressure				Blood clots/DVT			
Diabetes				Excessive bleeding			
Stroke				Bone loss/osteoporosis			
Asthma				Bone fracture(specify)			
Emphysema				Cancer(specify)			
Pancreatitis				Prior radiation exposure			

List any other medical problems that your doctors have diagnosed

Previous Surgery

Date		Type		Reason		Hospital	
Date		Type		Reason		Hospital	
Date		Type		Reason		Hospital	

List your prescribed drugs and over-the-counter drugs, including vitamins, supplements, and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications/foods	**Reaction You Had**

Social History/Lifestyle

Occupation		☐ If retired, former occupation	
Who lives at home with you?			
What kind of regular exercise do you get?		How many flights of stairs can you climb before becoming tired or short of breath?	☐ None ☐ One ☐ Two ☐ More than two
(Women) Are you pregnant? ☐ Yes ☐ No		(Women) Are you presently trying to conceive a child? ☐ Yes ☐ No	

Smoking	Pks/Day	Yrs smoked	Quit date	Alcohol	#Servings	☐ Monthly ☐ Weekly ☐ Daily

FAMILY HEALTH HISTORY

Do any of the following conditions run in your family?

☐ Thyroid disease (specify) _____
☐ High calcium
☐ High blood pressure
☐ Stomach ulcers

☐ Cancer (specify) _____
☐ Difficulty with anesthesia
☐ Excessive bleeding
☐ Others (list) _____

PLEASE DETAIL THESE AND ANY OTHER SIGNIFICANT FAMILY HEALTH PROBLEMS BELOW

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		Other/specify	☐ M ☐ F	
	☐ M ☐ F		Other/specify	☐ M ☐ F	

REVIEW OF SYSTEMS

Please explain any yes answers in the space provided

Constitutional:			**Gastrointestinal:**		
Fever or chills	☐ Yes ☐ No		Abdominal pain	☐ Yes ☐ No	
Weight loss / gain (circle)	☐ Yes ☐ No		Nausea or vomiting	☐ Yes ☐ No	
Feeling hot / cold (circle)	☐ Yes ☐ No		Heartburn	☐ Yes ☐ No	
Excessive thirst	☐ Yes ☐ No		Constipation / diarrhea (circle)	☐ Yes ☐ No	
Fatigue or low energy level	☐ Yes ☐ No		Bloody or black stools	☐ Yes ☐ No	
Loss of appetite	☐ Yes ☐ No				
Eyes:			**Genitourinary:**		
Blurred vision	☐ Yes ☐ No		Frequent urination	☐ Yes ☐ No	
Double vision	☐ Yes ☐ No		Painful urination	☐ Yes ☐ No	
Dry/irritated eyes	☐ Yes ☐ No		Blood in urine	☐ Yes ☐ No	
Ear/Nose/Throat/Mouth:			**Neurological/Psychological:**		
Ear infection	☐ Yes ☐ No		Memory loss or forgetfulness	☐ Yes ☐ No	
Difficulty swallowing	☐ Yes ☐ No		Depression or depressed mood	☐ Yes ☐ No	
Change in voice	☐ Yes ☐ No		Difficulty sleeping	☐ Yes ☐ No	
Respiratory:			**Integumentary:**		
Wheezing	☐ Yes ☐ No		Dry skin	☐ Yes ☐ No	
Shortness of breath	☐ Yes ☐ No		Itching	☐ Yes ☐ No	
Cough	☐ Yes ☐ No		Abnormal hair loss / growth (circle)	☐ Yes ☐ No	
Cardiovascular:			**Hematologic/lymphatic:**		
Chest pain	☐ Yes ☐ No		Swollen glands (location)	☐ Yes ☐ No	
Palpitations	☐ Yes ☐ No		Leg swelling one / both (circle)	☐ Yes ☐ No	
Musculoskeletal:			**Allergic/Immunologic:**		
Bone / joint pain (circle)	☐ Yes ☐ No		Seasonal allergies	☐ Yes ☐ No	
Back pain	☐ Yes ☐ No				
Muscle pain	☐ Yes ☐ No		**Other (list):**		
Muscle weakness	☐ Yes ☐ No			☐ Yes ☐ No	

AUTHORIZATION: I AUTHORIZE TRANSFER OF MY MEDICAL RECORDS TO THE UCLA ENDOCRINE CENTER AND AUTHORIZE COMMUNICATION FROM THE ENDOCRINE CENTER TO MY REFERRING PHYSICIANS (LISTED ON FRONT OF PAGE).

Print name:	Signed:	Date: