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:
  o Past operation reports
  o Pathology/biopsy reports
  o Radiology reports (scan results)
  o Doctor’s notes
  o Copies of all medical images on a CD (CAT scans, MRIs, nuclear medicine scans)
  o 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:
  o The Surgical Consultation Health History Form.
  o 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).
  o Contact information for your referring physician(s) and primary care doctor.
  o List of your current medications.
  o 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:
  o 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.
  o 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.
  o You will have the opportunity to ask questions.
  o If surgery is needed, we will schedule a date at the end of the visit.
**MEDICAL HISTORY**

Have you ever had any of the following conditions?

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>YES</th>
<th>NO</th>
<th>DATE</th>
<th>DISEASE</th>
<th>YES</th>
<th>NO</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina</td>
<td></td>
<td></td>
<td></td>
<td>Stomach ulcer</td>
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<td>Heart attack</td>
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<td>Liver disease/cirrhosis</td>
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<td>Heart failure</td>
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<td>Kidney disease/dialysis</td>
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<td>Heart murmur</td>
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<td>Kidney stones</td>
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<td>High blood pressure</td>
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<td>Blood clots/DVT</td>
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<td>Diabetes</td>
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<td></td>
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<td>Excessive bleeding</td>
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<td>Stroke</td>
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<td>Bone loss/osteoarthritis</td>
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<td>Asthma</td>
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<td>Bone fracture(specify)</td>
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<td>Emphysema</td>
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<td>Cancer(specify)</td>
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<td>Pancreatitis</td>
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<td>Prior radiation exposure</td>
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List any other medical problems that your doctors have diagnosed

**Previous Surgery**

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<th>Date</th>
<th>Type</th>
<th>Reason</th>
<th>Hospital</th>
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List your prescribed drugs and over-the-counter drugs, including vitamins, supplements, and inhalers

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<th>Strength</th>
<th>Frequency Taken</th>
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Allergies to medications/foods

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<th>Reaction You Had</th>
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### 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

#### Smoking

- Pks/Day
- Yrs smoked
- Quit date

#### Alcohol

- [ ] 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

<table>
<thead>
<tr>
<th>AGE</th>
<th>SIGNIFICANT HEALTH PROBLEMS</th>
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<th>SIGNIFICANT HEALTH PROBLEMS</th>
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#### REVIEW OF SYSTEMS

Please explain any yes answers in the space provided

**Constitutional:**
- Fever or chills
- Weight loss / gain (circle)
- Feeling hot / cold (circle)
- Excessive thirst
- Fatigue or low energy level
- Loss of appetite

**Eyes:**
- Blurred vision
- Double vision
- Dry/irritated eyes

**Ear/Nose/Throat/Mouth:**
- Ear infection
- Difficulty swallowing
- Change in voice

**Respiratory:**
- Wheezing
- Shortness of breath
- Cough

**Cardiovascular:**
- Chest pain
- Palpitations

**Musculoskeletal:**
- Bone / joint pain (circle)
- Back pain
- Muscle pain
- Muscle weakness

**Gastrointestinal:**
- Abdominal pain
- Nausea or vomiting
- Heartburn
- Constipation / diarrhea (circle)
- Bloody or black stools

**Genitourinary:**
- Frequent urination
- Painful urination
- Blood in urine

**Neurological/Psychological:**
- Memory loss or forgetfulness
- Depression or depressed mood
- Difficulty sleeping

**Integumentary:**
- Dry skin
- Itching
- Abnormal hair loss / growth (circle)

**Hematologic/lymphatic:**
- Swollen glands (location)
- Leg swelling one / both (circle)

**Allergic/Immunologic:**
- Seasonal allergies

**Other (list):**
- [ ] 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: ________________________