

## NEW PATIENT QUESTIONNAIRE – PITUITARY

Patient Name: \_\_\_\_\_ Age: \_\_\_\_ Referred by: \_\_\_\_\_

---

B/P: \_\_\_\_\_ HR: \_\_\_\_\_ Resp: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

What is the primary complaint that brought you here today?

How was your pituitary problem discovered?

Have you had difficulty with vision?	NO	YES	Have you seen an eye doctor?	NO	YES
Do you wear glasses?	NO	YES	Do you have double vision?	NO	YES

Have you had hormone problems?

- **Female:** Abnormality in your periods? Birth control pills?  
Date of your last menstrual period?  
Do you have children? Ages?  
Infertility problems? NO YES  
Have you had any spontaneous discharge from your breast?
- **Male:** Problems with sexual function that you would like to discuss with the physician? NO YES

Has there been any change in your weight?

Abnormal enlargement of hands or feet? Joint pain? Increased sweating?

Snoring and sleep apnea?

Have you had any hormone tests done? Where? Are you aware of results?

Has an MRI been done? Where?

Any previous problems with your nose?

Surgery Injury? Obstruction? Chronic leakage of clear fluid?

Do you have headaches? If so, how often? Please describe

Do you have a history of migraines or a family