NYU Medical Center

ENDOCRINE QUESTIONNAIRE

Name: _____
Last First

Guttman # _____

Soc. Sec. #: _____ Date of Birth: ___ ___ ___ Today's Date: ___ ___ ___
mo day yr mo day yr

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AFFIX LABEL HERE

1. Have you taken birth control pills in the past six months? no ☐ yes ☐

2. Have you taken female hormone pills - estrogens (such as PREMARIN), progestins, or others - in the past six months? no ☐ yes ☐

3. Have you been pregnant in the past six months? no ☐ yes ☐

4. Have you nursed a child in the past six months? no ☐ yes ☐

5. Have you had an ovary or part of an ovary removed? (This is done either as a separate procedure or at the same time as a hysterectomy.) no ☐ yes ☐ don't know ☐

IF YES: When? ___ ___
mo yr

Were both ovaries removed or just one? one only ☐ both ☐ don't know ☐

IF BOTH OVARIES WERE REMOVED: Were the ovaries removed totally or partially? totally ☐ partially ☐ don't know ☐

6. What is your address?

_____
No. Street Apt #

_____
City State Zip

7. What is your phone number? (___) _____ _____

DC 08/21/2019

8. Have you ever had breast cancer? no ☐ yes ☐
IF YES: When were you first diagnosed? ____ mo ____ yr

9. Have you ever had a mastectomy? no ☐ yes ☐
IF YES: When? ____ mo ____ yr

10. Have you ever had cancer of the ovary? no ☐ yes ☐
IF YES: When were you first diagnosed? ____ mo ____ yr

11. Have you ever had cancer of the uterus (endometrium)? no ☐ yes ☐
IF YES: When were you first diagnosed? ____ mo ____ yr

12. Have you ever had cancer of the colon? no ☐ yes ☐
IF YES: When were you first diagnosed? ____ mo ____ yr

13. Have you had any other type of cancer? no ☐ yes ☐
IF YES: What type? _____
When were you first diagnosed? ____ mo ____ yr

14. What is your weight? ____ lbs

15. What is your height? ____ ft. ____ in.

16. How old were you when you first began menstruating? ____ yrs.

17. Have you had at least one menstrual period in the past six months? no ☐ yes ☐

IF NO: What was the date of your last period? ____ mo ____ yr

IF YES: What was the date when your current menstrual period began? ____ mo ____ day ____ yr

During the past six months, how many menstrual periods did you have? ____ periods

During the past six months, what was the usual number of days in your mentrual cycle. (A menstrual cycle runs from the **first day** of one period to the **first day** of your next period.)
____ days
____ irregular
(time between periods varied by more than six days)

What was the longest period of time in the past six months during which you did not menstruate at all? ____ months

18. Have you ever been pregnant for a full term (7 mo. or longer)? no ☐ yes ☐

IF YES: How old were you at the end of your first full-term pregnancy? ____ yrs.

19. Have you had your uterus removed (hysterectomy)? no ☐ yes ☐

IF YES: When? ____ mo ____ yr

20. Have you ever had a breast biopsy or aspiration? no ☐ yes ☐

IF YES: In what year(s) was (were) the procedure(s) performed?
1st _____
2nd _____
3rd _____

What were the diagnoses?
1st _____
2nd _____
3rd _____

21. Was your mother ever diagnosed with breast cancer? no ☐ yes ☐

IF YES: What was her age at diagnosis? ____ yrs.

22. Do you have any sisters who have been diagnosed with breast cancer? no ☐ yes ☐

IF YES:
Number of sisters (total) ____
Number of sisters with breast cancer ____
Age(s) at diagnosis _____

23. What time was it when you last ate a meal or snack?

_____ : _____ AM
or _____ : _____ PM

24. Do you jog or run regularly?

no ☐ yes ☐

IF YES: How many miles (or minutes) per week on average?

_____ miles
_____ min.

25. Do you swim regularly?

no ☐ yes ☐

IF YES: How many miles, meters, laps, or minutes per week on average?

_____ miles
_____ meters
_____ laps
_____ min.

26. Do you ride a bicycle or exercise regularly?

no ☐ yes ☐

IF YES: How many miles (or minutes) per week on average?

_____ miles
_____ min.

27. The results of our study depend upon remaining in touch with you in the future. The following will be used **only in the event we cannot locate you.**

Please provide the names and addresses of two friends or relatives who will always know your whereabouts if you should move from your present address:

Name _____

_____
(street address)

_____
(city/zip)

Name _____

_____
(street address)

_____
(city/zip)

Husband's first name

_____

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FOR OFFICE USE

Fasting? no ☐ yes ☐

W _____ cm

H _____ cm

28. **In the last four weeks,** have you taken drugs in any of the following categories? If so, please check the box(es) of the appropriate category(ies) and list the specific drug(s):

DRUG CATEGORY	WHICH DRUG(S)?	HOW MUCH? (mg. or tablets per day)	WHEN LAST TAKEN
☐ Blood pressure medications or water pills			
☐ Pain killers such as ASPIRIN, MOTRIN, NAPROSYN, etc.			
☐ Major tranquilizers such as HALDOL THORAZINE, PROLIXIN, etc.			
☐ Minor tranquilizers such as VALIUM, LIBRIUM, DALMANE, or sleeping pills, etc.			
☐ Antidepressants such as TOFRANIL or ELAVIL, etc.			
☐ Anti-arthritic (anti-inflammatory) cortisone-type medications (including ointments) such as FLORINEF, PREDNISONE, MEDROL, KENALOG, HEXADRAL, etc.			
☐ Hormones used to bring on menstruation			
☐ Anti-convulsants such as DILANTIN or MYSOLINE, etc.			
☐ Medications for Parkinson's disease such as L-DOPA, SINEMET, SYMMETREL, etc.			
☐ Other medications including INSULIN, ANTI-BIOTICS, CHEMOTHERAPY for cancer, etc.			

☐ NONE TAKEN

PLEASE PROCEED TO THE DIETARY QUESTIONNAIRE