

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## Endocrine Questionnaire:

1. Do you have any blood relatives with the following...

A. Past history of neck surgery? \_\_\_\_\_

B. History of kidney stones? \_\_\_\_\_

C. Diagnosed with brain tumors? \_\_\_\_\_

D. Diagnosed with stomach ulcers? \_\_\_\_\_

E. History of high calcium levels? \_\_\_\_\_

F. History of pancreatic tumors? \_\_\_\_\_

2. Do you sing professionally? \_\_\_\_\_

3. Do you have any personal history of head and/or neck radiation? \_\_\_\_\_ if yes, when and for what reason? \_\_\_\_\_

4. Have you had previous neck surgery, including spinal fusions? \_\_\_\_\_ if yes, when and what location of the spine? \_\_\_\_\_