

**Questionnaire for Patients with Primary Hyperparathyroidism**  
**Dr. Julie Miller**

Name

Date

Please circle the appropriate answer. If you are unsure, discuss with me during the consultation.

**Do you or have you had any of the following medical conditions?**

Kidney Failure	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Peptic Ulcers	Yes	No
Pancreatitis	Yes	No
Gall stones	Yes	No
Kidney Stones	Yes	No
Osteoporosis	Yes	No
Broken Bones	Yes	No
Vitamin D deficiency	Yes	No
Psychiatric problems	Yes	No
Hypercalcemic crisis	Yes	No
Arthritis	Yes	No
Goiter/enlarged thyroid	Yes	No
Previous neck surgery	Yes	No

**Family members with parathyroid disease?**

Yes                      No

**Have you had any of the following symptoms?**

Frequent urination	Yes	No
Muscle weakness	Yes	No
Lethargy	Yes	No
General aches/pains	Yes	No
Heartburn	Yes	No
Increased forgetfulness	Yes	No
Abdominal pain	Yes	No

**Have you ever been exposed to radiation or had neck radiotherapy?**

Yes                      No