



Multidisciplinary Neuroendocrine Clinic
New Patient Workup:

Patient: _____ DOB: _____ Referring MD: _____

Symptoms/Signs:

Neurological		Comments
<input type="checkbox"/>	Migraines	
<input type="checkbox"/>	Vertigo	
<input type="checkbox"/>	Memory	
<input type="checkbox"/>	Speech	
<input type="checkbox"/>	Vision changes	
Endocrine		Comments
<input type="checkbox"/>	Decreased sex drive	
<input type="checkbox"/>	Erectile dysfunction	
<input type="checkbox"/>	Excessive sweating	
<input type="checkbox"/>	Heat/Cold intolerance	
<input type="checkbox"/>	Menstrual irregularity	
<input type="checkbox"/>	Breast swelling/discharge	
<input type="checkbox"/>	Change in physical appearance	

Endocrine Labs:

Female		
Test	Level	Date
FSH		
LH		
Prolactin		
IGF-1		
GH		
ACTH		
Cortisol		
TSH		
free T4		

Male		
Test	Level	Date
FSH		
LH		
Testosterone		
Prolactin		
IGF-1		
GH		
ACTH		
Cortisol		
TSH		
free T4		

MRI:

Date	Location	Contrast enhanced?