

PROLACTINOMA HISTORY

(IF YOU ARE UNABLE TO ANSWER A QUESTION, PLEASE LEAVE IT BLANK. – PLEASE PRINT)

Name: _____ Age: _____ Date of Birth _____

Date of diagnosis: _____

SYMPTOMS:

1. YES NO Breast milk discharge? Approx. onset: _____
 (a) Free flow? YES NO
 (b) Only when expressed? YES NO
 (c) Color: _____
2. YES NO Breast swelling or fullness?
3. YES NO Lack of menses? Approx. onset: _____
4. YES NO Irregular or decreased number of menses? Approx. onset: _____
5. YES NO Frequent headaches? Please describe: _____
6. YES NO Swelling of feet and/or legs? Approx. onset: _____
7. YES NO Change in vision?
8. YES NO Change in libido (sexual desires)? Approx. onset: _____
9. YES NO Painful intercourse? Approx. onset: _____
10. YES NO Change in hair on face or body? Decreased Increased Approx. onset: _____
11. YES NO Change in acne? Improved Worse Approx. onset: _____
12. YES NO Change in skin? Drier Greasier Approx. onset: _____
13. YES NO Change in bowel pattern? Diarrhea Constipation Approx. onset: _____
14. YES NO Change in weight? Weight _____ Loss Gain Approx. onset: _____
15. YES NO Tiredness or fatigue? Approx. onset: _____

PREVIOUS HISTORY:

16. YES NO Any previous pregnancy? (a) Number of pregnancies: _____ (b) Number of live births: _____
 (c) Number of miscarriages or abortions: _____ (c) Date of Last pregnancy: _____
17. Menstrual history: (a) Age at onset: _____ (b) Last menstrual period: _____
18. YES NO Unprotected intercourse? Approximate duration: _____
19. YES NO History of chest wall or spinal cord lesion or abnormality?
20. YES NO History of frequent suckling and nipple stimulation?
21. YES NO Known thyroid problem?
22. YES NO Previous pituitary or brain problems? (ie: infection, sarcoid, surgery, or radiation)
23. YES NO History of kidney or liver problems?
24. YES NO History of sarcoidosis?
 If answer to any of questions 19–24 is YES, please describe: _____

25. YES NO Use of oral contraceptive? If YES: (a) Onset: _____ (b) Last use: _____
26. Current/recent medications and duration of use: None
 (a) _____ (b) _____
 (c) _____ (d) _____
 (e) _____ (f) _____
27. YES NO Previous use of any of these medications? Check if indicated:
 Haldol Reglan (metoclopramide) Tagamet (cimetidine)
 Aldomet Thorazine (chlorpromazine) Antidepressants
28. YES NO Previous evaluation? (a) Prolactin level: _____ Approx. date: _____
 (b) Thyroid tests: _____ Approx. date: _____
 (c) CT/MRI of head: _____ Approx. date: _____

Results: _____

PROLACTINOMA HISTORY (cont'd)

29. YES NO Previous treatment for this condition? (see previous question #28) (If NO, skip to #30)
- YES NO (a) Medication(s):
1. Dose: _____
2. How did it work: _____
3. Side effects or problems: _____
- YES NO (b) Surgery:
1. Date(s): _____
2. Surgeon(s): _____
3. Location/Hospital(s): _____
- YES NO (c) Radiation:
1. Date(s): _____
2. Location/Hospital(s): _____

FAMILY HISTORY OF: (if YES, please list which relative)

- | | | | Relative(s) |
|-----|--|--|-------------|
| 30. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Prolactinoma: | _____ |
| 31. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Lack of menses: | _____ |
| 32. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Infertility: | _____ |
| 33. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thyroid: | _____ |
| 34. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Diabetes: | _____ |
| 35. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Other Pituitary problem(s): | _____ |
| 36. | <input type="checkbox"/> YES <input type="checkbox"/> NO | Known medicine allergies? (if YES, please list): | _____ |
| | | | _____ |
| | | | _____ |

37. YES NO Other surgeries or hospitalization(s) Please list:
- | Type | Location | Hospital | Date |
|---|----------|----------|-------|
| <input type="checkbox"/> surgery <input type="checkbox"/> illness | _____ | _____ | _____ |
| <input type="checkbox"/> surgery <input type="checkbox"/> illness | _____ | _____ | _____ |
| <input type="checkbox"/> surgery <input type="checkbox"/> illness | _____ | _____ | _____ |
| <input type="checkbox"/> surgery <input type="checkbox"/> illness | _____ | _____ | _____ |

38. YES NO Other medical problems? Please describe:
- _____
- _____
- _____
- _____
- _____
- _____
- _____