UPSTATE MEDICAL UNIVERSITY

Project ECHO® SUNY Upstate Medical University New York

Endocrinology TeleECHO™ Clinic

— PCOS/Hirsutism Presentation Template —

PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any SUNY Upstate clinician and any patient whose case is being presented in a Project ECHO® setting.

Date: ______________ **Presenter Name:** __________________________ **Clinic Site:** ________________

ECHO ID: __________ ☐ **New** ☐ **Follow Up** **Patient Age:** ______ **Biologic Gender:** ☐ Male or ☐ Female

Insurance: ☐ Medicaid ☐ Medicare, ☐ Private, ☐ None **Insurance Company:**_______________

Race: ☐ American Indian/Alaskan Native, ☐ Asian, ☐ Black/African American, ☐ Native Hawaiian/Pacific Islander, ☐ White/Caucasian, ☐ Multi-racial, ☐ Other _______________________, ☐ Prefer not to say

Ethnicity: ☐ Hispanic/Latino, ☐ Not Hispanic/Latino, ☐ Prefer not to say

Diagnosis: ☐ Polycystic Ovary Syndrome (PCOS) ☐ Hirsutism without PCOS **Date of Diagnosis:** _____________

Symptoms:

☐ Abnormal Menses	☐ Acne	☐ Easy Bruising	☐ Galactorrhea
☐ Hair Loss	☐ Headaches	☐ Hirsutism	☐ Infertility
☐ Mood Changes	☐ Muscle Weakness	☐ Visual Disturbances	☐ Weight Change: _______ ☐lbs. ☐ kgs.

☐ Other: _____________________________________

Past Medical History:

☐ Dyslipidemia	☐ Gestational Diabetes	☐ Gravida/Para: _________	☐ Hypertension
☐ Obesity	☐ Osteoarthritis	☐ Type 1 Diabetes	☐ Type 2 Diabetes

☐ Other: ______________________________________

Psychiatric History

Depression: PHQ9: _______ Date:_______

Medication Allergies: ____

Current Medications/Vitamins/Herbs/Supplements: Please feel free to attach your patient medication list

Med Name	Dosage & Frequency	Med Name	Dosage & Frequency
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Family History:

☐ Breast Cancer ☐ Diabetes ☐ Ovarian Cancer

Please send to: Margaret Greenfield – Project Coordinator— greenfma@upstate.edu
Phone: (315) 464-7898 • Fax: 315-464-8552

Smoking History: *Does patient currently smoke?* ☐ No ☐ Yes – Number of cigarettes per day (1 pack = 20): _________

Alcohol Consumption: *Does patient currently drink?* – ☐ No ☐ Yes – Number of drinks per week: __________

Vitals:

Date: _________________ Systolic BP: _____________ Diastolic BP: ____________ Pulse: _________________

Height: ________________ Weight: ________________ ☐lbs. ☐ kgs. BMI: __________________

Physical Exam:

☐ Abnormal Thyroid: ____

☐ Acanthosis ☐ Acne ☐ Cervicodorsal Hump ☐ Facial Plethora

☐ Hirsutism ☐ Male Pattern Baldness ☐ Moon Facies ☐ Proximal Muscle Weakness

☐ Violaceous Striae ☐ Other: ____

Current Labs:

Estradiol: ______________________ pg/mL

Free Testosterone: ______________________ ng/dL

Prolactin: ______________________ ng/mL

24 Hr. Urine Free Cortisol: ______________ mcg/24 hrs.

17 Hydroxyprogesterone: ____________________ ng/dL

Total Cholesterol: ______________________mg/dL

HDL: ______________mg/dL

Total Testosterone: ______________________ ng/mL

TSH: ______________________ uIU/mL

Hemoglobin A1c: ______________________ %

DHEA – Sulfate: ______________________ mcg/dL

Androstenedione: ____________________ ng/dL

Triglycerides: ________________________ mg/dL

LDL: ____________________ mg/dL

Pertinent Imaging Studies:

☐ Pelvic Ultrasound Date: ____________________ ☐ Normal ☐ Abnormal: ______________________

☐ Other: ____

Other Comments:

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