Patient Name: _____ DOB: _____

Endocrinology New Patient Information

Your Contact Information

Name: _____

Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Primary Care Physician Information

Name: _____

Address: _____

Phone Number: (____) _____ Fax Number (if known): (____) _____

Pharmacy Information

Name and location: _____

Phone Number: (____) _____ Fax Number (if known): (____) _____

Reason for Today's Visit:

_____

Past Medical History (please circle all that apply):

Coronary Artery Disease	Cataracts	Glaucoma	Migraines
Pancreatitis	Depression	COPD (emphysema)	Gout
Chronic Kidney Disease	Liver Disease	Asthma	Stroke/TIA
GERD (acid reflux)	Hyperlipidemia	Hypertension	Heart Failure
Kidney Stones	Sleep Apnea	Gallstones	Osteoporosis

Diabetes (if yes, when diagnosed and type 1 or type 2?) _____

Any diabetic complications (please circle): neuropathy, nephropathy, retinopathy

Date of last eye exam: _____

Cancer (if yes, what kind and what treatment?) _____

Please list any other medical conditions: _____

_____

Patient Name: _____ DOB: _____

Please list all surgical procedures and dates: _____

_____

_____

Drug allergies: _____

Please list all medications, including herbal and over-the-counter medications (include name of medication, dose, and frequency taken):

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

Social History

Marital Status: _____ Occupation: _____

Have you ever smoked cigarettes (circle one): Y N

If yes, # packs per day: _____ # years of smoking: _____ When did you quit? _____

Do you drink alcohol (circle one): Y N How much? _____

Do you or have you ever used illegal drugs: Y N Which ones? _____

Family History

Please list all members of your family who have diabetes: _____

Mother (illnesses): _____ Still living? Y N

Father (illnesses): _____ Still living? Y N

Siblings (# and health issues): _____

Children (# and health issues): _____

Any other pertinent family medical history: _____

OB/GYN History (for women)

of pregnancies: _____ # of live births: _____ # miscarriages or abortions: _____

Are your periods regular (circle one): Y N Date of last period: _____

Patient Name: _____ MR#: _____

Review of Systems: In the last 6 months, have you experienced any of the following symptoms? Respond to each.

Constitutional

Weight Loss (unintentional)	☐ Yes	☐ No
Weight Gain (unintentional)	☐ Yes	☐ No
Appetite Changes (↑ or ↓)	☐ Yes	☐ No
Fatigue (profound)	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No

Diabetes/Endocrine

Increased thirst	☐ Yes	☐ No
Increased urination	☐ Yes	☐ No
Frequent low blood sugars (hypoglycemia)	☐ Yes	☐ No
Severe hypoglycemia (requiring help from others)	☐ Yes	☐ No
Unawareness of hypoglycemia	☐ Yes	☐ No
Waking up at night to urinate	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Changes in hat/glove size	☐ Yes	☐ No
Enlarged thyroid (goiter)	☐ Yes	☐ No
Excessive sweating	☐ Yes	☐ No
Hair growth in unwanted areas	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No
Intolerance to cold or heat (if yes, circle one)	☐ Yes	☐ No

Eyes

Do you wear glasses or contacts (circle one if yes)	☐ Yes	☐ No
Dry eyes	☐ Yes	☐ No
Eye pain or drainage	☐ Yes	☐ No
Visual Changes	☐ Yes	☐ No

ENT/Mouth

Ear pain or drainage	☐ Yes	☐ No
Frequent sinus infections	☐ Yes	☐ No
Hearing changes or loss	☐ Yes	☐ No

Respiratory

Blood in your sputum	☐ Yes	☐ No
Coughing (lasting > 3 months)	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Cardiovascular

Chest pain or heaviness	☐ Yes	☐ No
Palpitations or rapid heart beat	☐ Yes	☐ No
Fainting or near fainting spells	☐ Yes	☐ No
Shortness of breath when lying flat in bed	☐ Yes	☐ No
Swelling of feet or legs	☐ Yes	☐ No

Gastrointestinal

Heartburn or Indigestion	☐ Yes	☐ No
Vomiting or nausea	☐ Yes	☐ No
Swallowing difficulty	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Blood in your stool	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea or frequent bowel movements	☐ Yes	☐ No

Psych

Anxiety without clear explanation	☐ Yes	☐ No
Sadness lasting for days or weeks	☐ Yes	☐ No

Genitourinary

Blood in your urine	☐ Yes	☐ No
Menstrual changes	☐ Yes	☐ No
Painful/difficult urination	☐ Yes	☐ No
Erection problems	☐ Yes	☐ No
Vaginal discharge or bleeding	☐ Yes	☐ No

Musculoskeletal

Broken bones	☐ Yes	☐ No
Joint pain or swelling	☐ Yes	☐ No
Muscle aches or weakness	☐ Yes	☐ No

Breasts

Masses or lumps	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No

Skin

Rashes or non-healing ulcers	☐ Yes	☐ No
New, rapidly growing, or changing moles	☐ Yes	☐ No
Unusual darkening of skin	☐ Yes	☐ No
Striae (purple stretch marks in skin)	☐ Yes	☐ No

Neurologic

Seizures	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Weakness of your extremities	☐ Yes	☐ No
Pain or burning in legs or feet	☐ Yes	☐ No
Numbness or tickling in legs or feet	☐ Yes	☐ No

Hematologic

Anemia	☐ Yes	☐ No
Easy bruising	☐ Yes	☐ No
Easy bleeding	☐ Yes	☐ No
Enlarged lymph nodes	☐ Yes	☐ No