ENDOCRINOLOGY NEW PATIENT FORM

Name:____________________________ **Primary Care Physician: _____________________**

What is your gender: □ Female □ Male □ Non-Binary: Preferred Pronoun: ______________

What is the best way to contact you: □ Phone ________________ OR □ Email: Follow My Health

Retail Pharmacy: ____________________ **Mail Order Pharmacy: ____________________**

List the problem(s) which has led to the referral to our endocrine clinic:

Review of Systems: Check any of those problems which you are currently experiencing:

General
- ☐ Weight changes Amount: _
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Skin
- ☐ Skin Rash
- ☐ Itchiness
- ☐ Purple stretch marks
- ☐ Darkened skin areas

Eyes
- ☐ Double or blurred vision
- ☐ Eye Irritation
- ☐ Bulging/Swelling of Eyes
- ☐ Diabetic Retinopathy

Cardiovascular
- ☐ Pain in chest
- ☐ Palpitations (racing heart)
- ☐ Leg Swelling (Edema)

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach pain

Genitourinary
- ☐ Frequent urination
- ☐ Sexual dysfunction
- ☐ Irregular Menses

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle Pains

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness or sensitivity
- ☐ Dizziness
- ☐ Fainting

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Endocrine
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hair growth
- ☐ Hair loss
- ☐ Goiter
- ☐ Breast/Nipple Discharge
- ☐ Change in ring or shoe size

For Women Only:

Age when periods began:______

Periods regular? □ Yes □ No

Have you gone through menopause?
□ Yes (age: ______) □ No

Do you plan to get pregnant in the near future?
□ Yes □ No

Number of pregnancies? ______

Number of miscarriages? ______

Please list your medication allergies and reaction to them:

Please list your medications (include supplements, herbal medicines, vitamins):

Social History:

Are you married or with a partner? _______________ **Do you have any children?** _________

Occupation: _______________

Do you exercise? ☐ Yes ☐ No

If yes, how many days per week at a moderate level (like a brisk walk) or greater: ___________
How many minutes each time: _____________

Do you smoke tobacco? ☐ Yes (per day:________________) ☐ Former ☐ No

Do you drink any alcohol? ☐ Yes (drinks per day:___________) ☐ Former ☐ No

Do you use recreational drugs? ☐ Yes (type:________________) ☐ Former ☐ No

You do not need to fill this page out if the information is already in your electronic chart

MEDICAL HISTORY: Check if you have (or had in the past) any of the following conditions:

	Pertinent details (date diagnosed, type of condition, etc.)
Diabetes	
High Blood Pressure	
High Cholesterol	
Heart Problems or Bypass Surgery	
Stroke	
Thyroid Problems	
Kidney Problems	
Cancer	
Osteoporosis	

Please list any surgeries you have had:

Type of Surgery and Date:

FAMILY HISTORY: check if any of your family members have any of the following conditions:

	Yes	No	Which Family Member, any details
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Problems or Bypass Surgery			
Stroke			
Thyroid Problems			
Kidney Problems			
Osteoporosis			
Cancer			
Other			

DIABETES HISTORY: Pease answer the questions below:

What type of Diabetes do you have: ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Unknown

At what age was your diabetes diagnosed? ________________________

Meter name: ______________________ Pump name:______________________

Do you check your blood sugars at home? □ Yes □ No

How many times a day do you check? ___________ Do you keep a blood sugar log? □ Yes □ No

What is your recent blood glucose level before you ate breakfast this morning? ____________

Do you ever have low blood sugars (below 70mg/dl)? __________ If yes, please answer the following:

Do you have symptoms when your blood sugars go low? ___________________

Have you ever been hospitalized for low blood sugars? ____________________

Have you been hospitalized for high blood sugars or had DKA? ______________

Have you ever seen a dietitian? □ Yes □ No

If yes, when was the most recent visit? ______________

How well do you follow your diabetic diet? ☐ Good ☐ Not very good ☐ Poor

Do you work night-shift: ☐ Yes (please list work hours_____________) ☐ No

Do you have any diabetes-related complications?

□ Eye problems: _____________ Last Eye Exam: ________________

□ Foot problems: ______________ Last Foot Exam: _______________

□ Kidney problems: _____________ Name of your Nephrologist (kidney doctor):___________

□ Heart problems: _______________ Name of your Cardiologist (heart doctor):_____________