(Office Use Only)
Patient Name: _____ **MR#** _____

ENDOCRINOLOGY: NEW PATIENT FORM

Date: _____/_____/_____ Age:
Patient Name: Date of Birth: _____/_____/_____
Social Security #: _____-_____-_____ Birth Place:
Home Phone: (_____)_____-_____ Cell/Wk. Phone: (_____)_____-_____
Address: _____
City : _____ State: _____ Zip: _____
Email: _____
Referring Physician: _____ Primary Care Provider: _____
Accompanied By: _____ ☐ Permission to discuss care in front of the above person.

REASON FOR TODAY'S VISIT: _____
Date when the symptoms began (approximate):

SYSTEM REVIEW: Do you currently suffer from any of the following? Place an 'X' in the No or Yes columns:

No	Yes	Constitutional	No	Yes	Cardiovascular	No	Yes	Reproductive	No	Yes	Integumentary
		Chills			Chest pain			------***Women Only***--------			Breast Discharge
		Fatigue			Leg swelling			Dysmenorrhea			Breast Lump
		Fever			Palpitations			Hot Flashes			Brittle Hair
		Malaise			Varicose veins			Irregular Menses			Brittle Nails
		Night sweats						------***Men Only***--------			Foot Ulcers
		Weight gain						Erectile Dysfunction			Hirsutism
		Weight loss						Penile Discharge			Hives
		Lethargy									Pruritus
No	**Yes**	**HEENT**	**No**	**Yes**	**Gastrointestinal**	**No**	**Yes**	**Neurological**			Rash
		Blurred vision			Abdominal pain			Dizziness			Skin Lesions/Sores
		Double vision			Blood in Stool			Fainting Spells	**No**	**Yes**	**Musculoskeletal**
		Difficulty Swallowing			Diarrhea			Headaches			Back pain
		Eye Discharge			Heartburn			Loss of Balance			Joint Pain
		Hearing Loss			Loss of appetite			Memory Loss			Joint Swelling
		Sore Throat			Nausea			Numbness/Tingling			Leg Pain
					Vomiting			Tremors			Muscle weakness
					Change in bowel habits						Neck Pain
No	**Yes**	**Respiratory**	**No**	**Yes**	**Genitourinary**	**No**	**Yes**	**Psychiatric**	**No**	**Yes**	**Hematologic**
		Chronic Cough			Dysuria			Anxiety			Easy bleeding
		Cough			Hematuria			Depression			Easy bruising
		Dyspnea			Polyuria			Insomnia			
		Shortness of Breath			Frequent Urination			Hallucinations			
		Wheezing			Urinary Incontinence	**No**	**Yes**	**Metabolic/Endocrine**	**No**	**Yes**	**Immunological**
					Urinary retention			Cold intolerance			Environmental Allergies
					Kidney Stones			Heat intolerance			Contact Dermatitis
								Abnormal Thirst			Latex Allergy

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MEDICAL HISTORY: *Place a Check in the box next to the following conditions you have been diagnosed with:*

☐ Adrenal Disease	☐ COPD	☐ Hyperlipidemia	☐ Parathyroid Disease
☐ Allergies	☐ Depression	☐ Hypertension	☐ Pituitary Disease
☐ Anemia	☐ Diabetes Type I	☐ Hyperthyroidism	☐ Prostatic Hypertrophy (Benign)
☐ Angina	☐ Diabetes Type 2	☐ Hypogonadism	☐ Renal Disease
☐ Arthritis	☐ Diabetes Gestational	☐ Hypothyroidism	☐ Seizure Disorder
☐ Anxiety	☐ Gallbladder Disease	☐ Irritable Bowel	☐ Sleep Apnea
☐ Asthma	☐ GERD	☐ Kidney Stones	☐ Stroke
☐ Atrial Fibrillation	☐ Headaches	☐ Migraines	☐ Systemic Lupus
☐ Blood Clots	☐ Heart Disease	☐ Myocardial Infarction	☐ Thyroid Disorder
☐ Cholesterol	☐ Heart Vale Disorder	☐ Obesity	☐ Tuberculosis (TB)
☐ Congestive Heart Failure		☐ Osteoporosis	☐ Ulcer of Stomach or Bowel
☐ Coronary Artery Disease			

☐ Hepatitis/Liver Disease: ☐A ☐B ☐C ☐D ☐E ☐F ☐GBV-C ☐Autoimmune ☐Drug Induced ☐:_____

☐ Cancer (list type:) ☐Bladder ☐Breast ☐Colon ☐Gastric ☐Lung ☐Thyroid ☐Neck ☐Ovarian ☐:_____

☐ Renal (Kidney) Disease: ☐ On Dialysis ☐Stage 1-2 ☐Stage 3-4 ☐Stage 5(end) ☐:_____

☐ Other: _____

Women Only: Are you pregnant? ☐ No ☐ Yes, if Yes _____ weeks pregnant Nursing? ☐ No ☐ Yes

Immunizations: Date of last Flu Shot_____ Date of last Pneumonia Shot:_____

DIAGNOSTIC HISTORY: *Place a Check in the box next to the testing that apply:*

	Body Part	*Date*	*Facility*
☐ Last MRI			
☐ Last CT			
☐ Fine Needle Aspiration			
☐ X-Rays			
☐ Ultra Sound			
☐ Other Testing			

SURGICAL HISTORY: *Place a Check in the box next to the following surgeries you have had:*

	Specify Type & Surgeon	***Date***		***Specify Type & Surgeon***	***Date***
☐ Amputation			☐ Hip Replacement		
☐ Angioplasty			☐ Hysterectomy		
☐ Appendectomy			☐ Knee Replacement		
☐ Back Surgery			☐ Mastectomy		
☐ Blood Transfusion			☐ LASIK		
☐ Bypass			☐ Small Bowel Resection		
☐ Cardiac Pacemaker			☐ Thyroidectomy		
☐ Carpal Tunnel			☐ Tonsillectomy		
☐ Cataract Extraction			☐ Other:_____		
☐ Cholecystectomy			☐Other:_____		
☐ C-Section			☐ Other:_____		
☐ Colostomy			☐Other:_____		
☐ Hernia Repair			☐Other:_____		

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FAMILY HISTORY: *Circle the letter that represents the family member: Mother (M), Father (F), Sister (S), Brother (B)*

Father: ☐ Alive & Well ☐ Deceased, Cause of Death:_____ Age:____
Mother: ☐ Alive & Well ☐ Deceased, Cause of Death:_____ Age:_____

Adrenal Disease	M	F	S	B	Diabetes 1	M	F	S	B	Obesity	M	F	S	B
Allergies	M	F	S	B	Diabetes 2	M	F	S	B	Osteoporosis	M	F	S	B
Alzheimer's disease	M	F	S	B	Eczema	M	F	S	B	Parathyroid Disease	M	F	S	B
Arthritis	M	F	S	B	Hypertension	M	F	S	B	Parkinson's	M	F	S	B
Asthma	M	F	S	B	Hyperthyroidism	M	F	S	B	Peripheral Vascular Disease	M	F	S	B
Blood disorder	M	F	S	B	Hyperlipidemia	M	F	S	B	Pituitary Disease	M	F	S	B
Cancer (type):_____	M	F	S	B	Hypothyroidism	M	F	S	B	Renal Disorder	M	F	S	B
Cardiovascular Disease	M	F	S	B	Irritable bowel disease	M	F	S	B	Seizure Disorder	M	F	S	B
Congenital Heart Failure	M	F	S	B	Kidney Stones	M	F	S	B	Stroke	M	F	S	B
COPD	M	F	S	B	Liver Disease	M	F	S	B	Thyroid Disorder	M	F	S	B
Coronary Artery Disease	M	F	S	B	Migraines	M	F	S	B	Thyroid Nodules	M	F	S	B
Depression	M	F	S	B	Other:_____	M	F	S	B	Other:_____	M	F	S	B

SOCIAL HISTORY:

Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children: ☐ Boy(s) #_____ ☐ Girl(s) #_____

Education: *circle highest level attended* **Grade School:** 7 8 9 10 11 12 **College:** 1 2 3 4 **Degree(s):** _____

Work: Occupation _____ ☐ Part-time ☐ Full-time -Average # of hours work per week: ____

☐ Retired, Age at Retirement:_____ ☐ Disabled, Age at Disability:_____

Spouse Work: Occupation _____ ☐ Part-time ☐ Full-time

Tobacco: Do you use tobacco? ☐ No/Never ☐ Yes ☐ Former - How long ago? _____ Age Quit:_____

Tobacco Type: ☐ Cigarette ☐ Cigarillo ☐ Cigar ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff ☐ Vape

Smoker Status: ☐ Current every day Smoker ☐ Current some day Smoker ☐ Heavy Smoker ☐ Light Smoker

Caffeine: Do you drink caffeinated beverages ☐ No ☐ Yes, what type: _____ Cups per day: _____

Sleep Patterns: How many hours of sleep do you get at night? ____ Trouble falling asleep? ☐ No ☐ Yes

Difficultly staying asleep? ☐ No ☐ Yes Do you wake up frequently? ☐ No ☐ Yes

Alcohol: Do you drink alcohol? ☐ No ☐ Yes If Yes, what type of alcohol? _____ Amount: _____

Frequency: ☐ daily ☐ weekly ☐ monthly ☐ socially ☐ occasionally ☐ rarely

Has anyone ever told you to cut down on drinking? ☐ No ☐ Yes

Travel History: Have you traveled outside the USA? ☐ No ☐ Yes , where/when?

Lifestyle: Do you exercise regularly? ☐ No ☐ Yes Type of exercise: _____Gym Membership: ☐ No ☐ Yes

Level of Activity: ☐ Sedentary ☐ Moderate ☐ Vigorous

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Allergies to Medications : *List any allergies or intolerances to medications & include your reaction*	
Medication Allergy	**Reaction(s)**
Are you allergic to IODINE? ☐ No ☐ Yes If yes, what happens?_____	

Medications: *(List all current medications you are taking)*

Medication	Dose (strength & quantity)	Prescribing Doctor
1.		
2.		
3.		
4.		
5.		
6		
7.		
8.		
9.		
10.		
11.		
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