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Board Certified Endocrinology, Diabetes and Metabolism

Patient Information

Referred by: ______________
Last name: ______________ First name: ____________ Middle: ____________
Street addr: ______________________________ City: ________ ST: ____
Zip Code: ________ Home Phone: ( ) ____________ Cell: ____________
Maiden Nm ____________ DOB: ______________ Social: ____________
Marital Status: ____ S ____ M ____ Other ____
Email address: ______________________________

Employer: ______________________ **Occupation:** __________
Driver Lic: ______________________ **State:** ____________

Spouse/ Parent / Guardian Name: ____________________ DOB: ____________
Social Security: ____________ Work # ( ) __________ Cell: ____________
EMERGENCY CONTACT Name ____________________ Phone: ____________

Insurance Information

Name of Primary Ins: ________________________ **Co-Pay amount $** ______
Policy No. ____________________________ Group No. ____________________
Insurance Claims Address: ____
Insurance Phone No. ______________________
Insured last name: ____________________ Insured first name: ____________
Relationship to Patient: ______________ DOB: ________
Insured address (if different from patient) ______________________________
Insured Employer: ________________________ Ins Employer No. __________

Name of Secondary Insurance : ____________________ **Co-Pay amount $** ______
Policy No. ________________________ Group No. ____________________
Insurance Claims Address: ____
Insurance Phone No. ____________________
Insured last name: __________________ Insured first name: ______________
Relationship to Patient: ________________ DOB: ________
Insured address (if different from patient) __________________________+__________
Insured Employer: __________________________ Ins Employer No. __________

Payment Policy

I understand that I am ultimately responsible for any balance that accumulates and agree to pay any balance due after insurance has paid or responded

Authorization of Payment

*I hereby authorize **Diabetes and Metabolism Specialists** to release Medical Information concerning my examination and/or treatment for insurance purposes and to receive direct payment for Medical benefits payable to me for services rendered. Signed: ______________________ Date: ________*

Medical History

Patient Name: ______________________ M/F: ______ Date of birth: ____________
Preferred Name /nick name: ____________ Age: ____________
Primary Doctor: ______________________
Referring Doctor: ____________________
Referring friend/family member: ______________________

Past Medical History: Check all that apply and provide date of onset of disorder

Disorder	Date of Onset
❍ Diabetes Mellitus, Type 1	______________
❍ Diabetes Mellitus, Type 2	______________
❍ Hypothyroidism (Low Thyroid)	______________
❍ Hyperthyroidism (High Thyroid)	______________
❍ High Blood Pressure (HTN)	______________
❍ High Cholesterol	______________
❍ Thyroid Nodules	______________
❍ Thyroid Cancer	______________
❍ Hypoparathyroidism	______________
❍ Hyperparathyroidism	______________
❍ Hypercalcemia (High Calcium)	______________
❍ Osteopenia	______________
❍ Osteoporosis	______________
❍ Bone Fractures	______________
❍ PCOS (Polycystic Ovarian Syndrome)	______________
❍ Menstrual Irregularities	______________
❍ Hirsutism (increased facial hair)	______________
❍ Menopausal Symptoms	______________
❍ Pituitary Problems	______________
❍ Pituitary Tumor	______________
❍ Adrenal Disorder	______________
❍ Weight Gain	______________
❍ Hair Loss	______________
❍ Infertility	______________
❍ Coronary Artery Disease	______________
❍ Stroke	______________
❍ Kidney Disease (CKD)	______________
❍ Dialysis	______________
❍ Diabetic Eye Problems	______________
❍ Neuropathy	______________

Other Medical History:

____
____
____
____

Past Surgical History: check all that apply with dates

SURGERY	Date
❍ Appendectomy	________
❍ Tonsillectomy	________
❍ Adenoidectomy	________
❍ Hysterectomy, Partial	________
❍ Hysterectomy, Complete	________
❍ Gall Bladder (laproscopic cholecystectomy)	________
❍ Gall Bladder (open cholecystectomy)	________
❍ CABG (heart bypass)	________
❍ Thyroidectomy, Partial	________
❍ Thyroidectomy, Complete	________
❍ Parathyroidectomy	________
❍ TSS (Pituitary Surgery)	________
❍ Gastric By-pass surgery	________
❍ Lap Band Surgery	________

Other Surgeries:

____
____
____
____

Social History:

- ❍ Single
- ❍ Married
- ❍ Divorced
- ❍ Widowed
- ❍ Smoker: ______ packs per day
- ❍ Nonsmoker
- ❍ Second Hand Smoke
- ❍ Quit smoking _______ years ago
- ❍ Rare alcohol
- ❍ Social alcohol: number of drinks per week: ______________
- ❍
- ❍ Children Number of Children _______

Any Medical Problems: ____________________________________

Family History:

- ❍ Diabetes mellitus, Type 1
- ❍ Stroke
- ❍ Thyroid problems
- ❍ Diabetes mellitus, Type 2
- ❍ Heart Attack (MI)
- ❍ Pituitary problems
- ❍ High blood pressure (HTN)
- ❍ Cancer
- ❍ Osteoporosis
- ❍ High cholesterol
- ❍ Obesity

OB/GYN History:

Number of Pregnancies: ___________ Number of Live Births: __________

Number of Children: ______________

Age of onset of menstrual period _______ Age at last period: ________

Allergies to Medications: ______________________________

Osteoporosis History:

List any Bone Fractures: ______________________________

Family History of Osteoporosis: ______________________________

Have you taken prednisone (or other steroid) for more than 4 weeks?: ______________

Do you take more than 1000mg of calcium per day? ______________________________

Do you take more than 1,000 IU of Vitamin D 3 per day? ________________________

Have you lost more than 1 inch in height? ______________________________

Do you have bone pain? ______________________________

List all vitamins, supplements, or natural products:

Name of supplements	Dosage	Times per Day

Medication List:

Pharmacy Name: ______________________ Pharmacy number: (   ) _______-_________

Pharmacy Fax Number: (   )________-_____________

Name of Medication	Dosage	Times per Day