NEW PATIENT INFORMATION FORM

SUBURBAN ENDOCRINOLOGY AND DIABETES

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Patient:____ Date:______________

How many finger sticks / day________ ☐ Pen ☐ Vial

HISTORY:

REASON FOR VISIT (chief complaint): ________________________________

TO BE FILLED OUT BY M.D.

HISTORY OF PRESENT ILLNESS: • For a Level 3, 4, 5, history, document at least 4 of these elements or status of ≥ 3 chronic or inactive problems

- Location ______________________
- Quality ______________________
- Severity ______________________
- Duration ______________________
- Timing ______________________
- Context ______________________
- Associated signs/symptoms ______________________
- Modifying factors ______________________

MEDICAL HISTORY:

- For a level 3 history - at least 1 specific item for ANY ONE of the 3 histories
- For a level 4 & 5 history - at least 1 specific item for EACH ONE of the 3 histories

(A) • Patient medical history/past history

Diabetes........................ No Yes
Hypertension........................ No Yes
Cancer........................ No Yes
Stroke........................ No Yes
Heart trouble........................ No Yes
Thyroid........................ No Yes
Other:______________________
____
____
____
____

Previous Hospitalizations/Surgeries/Serious Injuries When?
____
____
____
____

Radiation Treatment (Type & Age)______________________

Medications and doses
____
____
____

Past medications: ______________________

(B) • Patient social history

Marital status:	Single____	Married____	Separated____	Divorced____	Widowed____
Use of alcohol:	Never____	Rarely____	Moderate____	Daily____	
Use of tobacco:	Never____	Previously, but quit____		Current packs/day____	
Use of drugs:	Never____	Type/Frequency______________________			

(C) • Family medical history Disease

	Age	Diabetes	Heart Disease	Hypertension	Thyroid	Cancer	Other	If Deceased, Cause of Death
Father								
Mother								
Siblings								
Spouse								
Children								

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PATIENT NAME ______________________

SYSTEM REVIEW:
- For a level 3 system review - at least 2 systems
- For a level 4 & 5 system review - at least 10 systems (Dictate responses to pertinent systems, then state "All other systems negative"

• CONSTITUTIONAL SYMPTOMS	No	Yes
Good general health lately	No	Yes
Recent weight change Gain? Or loss?	No	Yes
Fever, chills	No	Yes
Fatigue	No	Yes
Height loss	No	Yes

• EYE PROBLEMS	No	Yes
Eye bulging	No	Yes
Eye lid problems	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes

• EARS/NOSE/MOUTH/THROAT PROBLEMS	No	Yes
Hearing loss or ringing	No	Yes
Dental problems	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

• CARDIOVASCULAR PROBLEMS	No	Yes
Heart trouble What Kind ______	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitations	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes
Fainting	No	Yes

• RESPIRATORY PROBLEMS	No	Yes
Chronic or frequent coughs	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

• GASTROINTESTINAL PROBLEMS	No	Yes
Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea or frequent BM	No	Yes
Painful bowel movements or constipation	No	Yes
Abdominal pain	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

• GENTIOURINARY PROBLEMS	No	Yes
Frequent urination	No	Yes
Kidney stones	No	Yes
Fertility problems	No	Yes
Female – irregular periods	No	Yes

Female – # pregnancies __________ # miscarriages __________

Female – # live births __________

Female – date of LMP __________

Female – age of 1st period __________

Male – age when started shaving __________

Male – erectile problem	No	Yes

• MUSCULOSKELETAL PROBLEMS	No	Yes
Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles	No	Yes
Muscle pain or cramps	No	Yes
Back Pain	No	Yes
Fracture, which bone ______	No	Yes

• (BREAST/SKIN) INTEGUMENTARY PROBLEMS	No	Yes
Breast pain or enlargement	No	Yes
Breast lump	No	Yes
Nipple discharge	No	Yes
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes

• NEUROLOGICAL PROBLEMS	No	Yes
Headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations Where ______	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Neuropathy	No	Yes
Acne	No	Yes
Excessive sweating	No	Yes

• PSYCHIATRIC PROBLEMS	No	Yes
Nervousness/anxiety	No	Yes
Depression	No	Yes
Insomnia/poor sleep	No	Yes

• ENDOCRINE PROBLEMS	No	Yes
Glandular or hormone problem which one ______	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat, glove, shoe or ring size	No	Yes

• HEMATOLOGIC/LYMPHATIC PROBLEMS	No	Yes
Anemia	No	Yes
Enlarged lymph glands	No	Yes
Blood clots	No	Yes

• ALLERGIC IMMUNOLOGIC PROBLEMS	No	Yes

History of adverse reaction to:

Drugs __________

Other __________

M.D. Initials	Date	M.D. Initials	Date

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