Telendocrine, LLC
www.telendocrine.com

New Patient Information

Personal Information

Name:_____ DOB:_____

SS#_____

Address:_____

City:_____ State:_____ Zip Code: _____

Race: _____

Sex: Male_____ Female_____

Email: _____

Home Phone: _____ Work Phone: _____Cell Phone:

_____

Emergency Contact Person:_____ Relationship:_____

Phone: _____

I agree to pay a $25 fee in the event that I do not show up for my appointment or cancel within 24 hours.

Your regular or referring medical provider (PCP, Ob-Gyn, etc.): Name:

_____

Address / Location: _____

Do you want your office notes sent to your doctor? Yes No

Your regular pharmacy: Name & location: _____

Your compounding pharmacy (if applicable): _____

Your medical history (hypothyroidism, diabetes, hypertension, etc.):

_____

_____

_____

_____

_____

Allergies & sensitivities: _____

_____

_____

Previous major surgeries: _____

_____

_____

_____

Major diseases in immediate family members (parents, siblings, children):

_____

_____

Current medications & vitamins (name, dose, how often taken):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other: Marital status: _____ Occupation: _____

Alcohol use: Never Almost never Socially Daily More than daily

Current cigarette / cigar smoker? Yes No Packs per day: _____ If previous smoker, when did you quit? _____ Are you exposed to second hand smoke in your house?_____