Conroe Endocrinology Center
150 Pine Forest Dr, Suite 103
Shenandoah, TX 77384
Tel.: 936-755-4238, Fax: 936-755-5979

New Patient Packet

In order to best meet your needs during your office visit, we request that you provide us with the following information for your treatment. Please fill-in or circle what applies. Please be aware that demographic questions are designed to meet Government specified Meaningful Use Criteria for medical records and our Electronic medical record template.

## Patient Demographics

**Patient's Name**: _____ **DOB**:_____

**Gender**: Male Female **Social Security number**_____

**Address**: _____

Tel. Numbers (circle preferred choice): Home:_____ Work:_____

Cell: _____ allow to send text message for appointments YES NO

Email Address: _____ Other Contact_____

**Primary Language**: _____ **Ethnicity**: Are you of Hispanic, Latino or Spanish origin: YES NO

**Race**: American Indian, Asian, Asian Indian, Black or African-American, European, Filipino, Japanese, Hawaian/Other Pacific Islander/, Korean, White/Unknown

**Marital Status**: Single/Married/Divorced/Separated/Widowed/Partner/Unknown
**Home Bound**: YES NO **Patient care summary**: Portal Paper
**How did you hear about us**: referral; patient from prior practice; word of mouth; internet; insurance

Agree to receive **automated phone calls** on preferred number about appointment reminders and normal test results: YES NO

Agree to download the patient's **medication history** from pharmacy benefit manager (PBM): YES NO

**Guardian** (if available) First Last name_____

**Emergency contact**: Name/relationship/ tel._____

_____

Consent to discuss your medical information with emergency contact: YES NO

**Next of Kin**: Name/relationship/ tel._____

**Employer**: Name/occupation/tel._____

**Guarantor**: First Last name_____ relationship_____

Guarantor address and tel._____

_____ social security number of guarantor_____

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Your name and DOB_____

Information Insurance Company: _____

Local pharmacy name, zip code and tel.: _____

_____

Mail order pharmacy:

_____

Referring provider name and tel._____

Primary care provider name and tel._____

Last visit date:_____

Eye care provider name and tel._____

Last visit date:_____

Podiatrist name and tel. _____

Last visit date:_____

Cardiologist name and tel._____

Last visit date:_____

Kidney specialist name and tel._____

Last visit date:_____

OBGYN name and tel._____

Last visit date: _____

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Your name and DOB_____

What is the main reason for you office visit today? _____

Date of Diagnosis_____,

Do you have any allergies to any medications? No If yes, please list medications and side effects below:

_____

_____

Current Medications: NAME DOSAGE TIMES PER DAY TAKEN

_____

_____

_____

_____

_____

_____

Please indicate previous medications taken for your diagnosis and reason for discontinuation:

_____

_____

_____

_____

Current and past medical problems:

Heart problems:_____ Blood pressure problems:_____

Eye problems_____ Nutritional/vitamin deficiency_____

Nerve problems:_____ Mood problems_____

High blood sugar:_____ Low blood sugar_____

Thyroid Problems:_____ Testosterone problems_____

Lung problems:_____ Stomach problems_____

Bone/calcium problems:_____ Adrenal conditions:_____

Fertility/menstrual cycle problems_____

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Your name and DOB_____

**Past surgical History**: Please list your prior surgeries and dates

_____

_____

_____

**Family medical history** and Age of Onset

Disease:_____ Relationship: _____ Age: _____
Disease: _____Relationship: _____ Age: _____
Disease: _____ Relationship: _____ Age: _____
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**Social History:**

Children & ages: _____ Caregiver: _____Hobbies: _____
Exercise: _____(type)_____(times/week)_____(duration)_____

Smoking History: _____ Alcohol Intake: _____

Illicit Drug Intake (present and/or past): _____

**Medical Review of Systems**: (please circle if you have any of these symptoms)

| **General** | **Head/Neck/Ears** | **Eyes** |
|---|---|---|
| Weight changes | Headaches | Blurry Vision |
| Fatigue/Tiredness | Neck Pain | Blindness |
| Fever/Chills | Hearing impairment | Eye pain |
| Loss of appetite | Ringing in Ears | Double vision |
| **Mouth/Throat** | **Cardiovascular** | **Respiratory** |
| Voice changes | Palpitations | Shortness of Breath |
| Difficulty swallowing | Chest pain | Cough |
| Neck pain/pressure | Swelling of the ankles | Wheezing |
| **Breast** | **Psychiatric** | **Males only** |
| Nipple discharge | History of Mental illness | Decreased libido |
| Breast pain | Anxiety | Erectile dysfunction |
| Rapid breast enlargement | Depression | Penile discharge/skin changes |
| **Gastrointestinal** | **Urinary** | **Musculoskeletal** |
| Nausea/Vomiting | Frequent urination | Joint pain/back pain |
| Constipation | Painful urination/blood in urine | Muscle weakness/cramps |
| Diarrhea | Increase in urination at night | Fractures |
| Abdominal pain/Heartburn | Inability to pass urine | Joint swelling/stiffness |
| **Skin** | **Neurologic** | **Endocrine** |
| Rashes | Seizures | Increase in thirst |
| Itching/skin discoloration | Weakness/Dizziness/Fainting spells | Changes in heat/cold perception |
| Changes in body hair | Loss of sensation/tingling | Changes in height/shoes/ring size |
| Skin lesions/acne | Trembling of arms/legs | Budging of eyes |
| Swollen lymph nodes | Sleep problems/sleep apnea | Irregular menstrual cycles/infertility |

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Your name and DOB_____ **Patients with Diabetes only**:

Glucose Monitoring: Type of Meter: _____ Testing Frequency: _____/day

Average Blood Glucose: AM: _____Lunch: _____ Supper: _____ Bedtime: _____
Low Blood Glucose: YES or NO Frequency of low blood glucose: ___/week I feel low at_____/mg/dl

Mostly eat HOME/ EAT OUT Family support for diabetes_____ Barriers for control_____

Previous Hemoglobin A1C: Date: _____ Value: _____ I have Diabetes type 1 /2 /gestational

Complications: Retinopathy: YES or NO Laser Treatment: YES or NO Last Eye exam: _____

Nerve damage: YES or NO Heart problems or stroke: YES or NO High Blood Pressure: YES or NO

Diabetic Kidney Problems: YES or NO Sexual Problems: YES or NO High Cholesterol: YES or NO

Diabetic ketoacidosis: YES NO History of Gestational Diabetes: YES NO Given birth to child over 9lb: YES

Hospitalization due to low or high glucose: YES or NO COMMENTS: _____

If on insulin pump what type_____ started in_____ insertion type _____changing _____days

If on glucose sensor what type_____ changing every _____days Probles with site YES NO

**Women Only** Last Menstrual Period: _____ Are you pregnant? YES NO
Periods regular or irregular: _____ Previous Pregnancies: _____

Menopause since_____ last mammogram_____

**Vaccination history**: date of last pneumonia vaccine_____ last flu vaccine_____

**Depression screen: please circle numbers in columns that correspond to your mood**

| **Over past 2 weeks how often you were bothered by any of the following problems?** | **Not At All** | **Several Days** | **More Than Half the Days** | **Nearly Every Day** |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling asleep, staying asleep or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tiered or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself/I am a failure | 0 | 1 | 2 | 3 |
| Trouble concentrating on things/tasks | 0 | 1 | 2 | 3 |
| Moving/speaking too slow or too fast | 0 | 1 | 2 | 3 |
| Thoughts about hurting yourself | 0 | 1 | 2 | 3 |

If you checked off any problems how difficult at all have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult_____ Somewhat difficult_____ Very difficult_____ Extremely difficult_____
Signature:_____Date:_____

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