Endocrinology and Diabetes Associates

Date:_____ Referring Physician:_____

PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION:

First Name:_____ MI:_____ Last Name:_____

Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Telephone: (_____)_____ Cell/Alternate:(_____)_____

Sex: _____DOB: _____SSN:_____Marital Status:_____

Patient's Employer:_____

Employer's Address:_____

City:_____ State:_____ Zip:_____

Employer Phone: (_____)_____

If patient is over 18 and a student, please check one: ____Employed ____Part-time ____Full-time student

In case of Emergency Contact:_____Relationship:_____Phone #:_____

BILLING INFORMATION:

First Name:_____ MI:_____ Last Name:_____
Address:_____ Apt #:_____
City:_____ State:_____ Zip:_____
Telephone: (_____)_____ Cell/Alternate:(_____)_____

INSURANCE INFORMATION:

Primary Insurance:_____
Group Number:_____Policy Number:_____
Subscriber Name:_____
Subscriber Sex:_____DOB:_____SSN:_____
Subscriber Employer:_____

Secondary Insurance:_____
Group Number:_____Policy Number:_____
Subscriber Name:_____
Subscriber Sex:_____DOB:_____SSN:_____
Subscriber Employer:_____

Endocrinology and Diabetes Associates

NAME:_____ **REFERRING PHYSICIAN**:_____
AGE:_____

MEDICAL ILLNESSES:

_____ _____
_____ _____
_____ _____
_____ _____

SURGERIES: (Please include any scheduled surgeries.)

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS: (Include non-prescription and vitamins, if any)

RX:_____DOSAGE:_____ TIMES DAILY:_____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

DRUG ALLERGIES:

_____ _____
_____ _____
_____ _____
_____ _____

FAMILY MEDICAL HISTORY:

Ages (if living)	Illnesses
Mother	
Father	
Sister(s)	
Brother(s)	
Children	

Indicate any significant illnesses outside immediate family (diabetes, thyroid disease, tumors, heart disease, etc.):
_____

HABITS:	Yes	No
Tobacco:	_____	_____
Alcohol:	_____	_____
Recreational Drugs:	_____	_____

REVIEW OF SYSTEMS – CIRCLE IF YOU HAVE A CURRENT PROBLEM

SKIN
Pigment Change
Itching
Scaling
Hair Loss
Nail Brittleness

LYMPH NODE
Enlarged
Painful
Draining

BONES, JOINTS, MUSCLES
Fractures, Sprains
Arthritis
Pain
Night Cramps
Weakness

BLOOD
Anemia
Bleeding
Bruising

ENDOCRINE
Change in Ring Size
Goiter
Dry Skin, Hair
Cold Intolerance
Abnormal Weight Gain
Increased Thirst
Change in Appetite
Increased Urination
Impotence
Menstrual Irregularity
Tiredness
Heat Intolerance
Abnormal Weight Loss

IMMUNOLOGIC
Hay Fever
Rash

GU
Frequent Urination
Pain on Urination
Kidney Stones

EYES/EARS
Visual Loss
Deafness
Tinnitus (ringing ears)

BREAST
Discharge
Lumps
Pain

RESPIRATORY
Hoarseness
Sinusitis
Shortness of Breath
Wheezing
Asthma
Bronchitis
Emphysema
Cough
Tuberculosis

CARDIOVASCULAR
Chest Pain
Palpitations
Irregular Heart Beat
Orthopnea
Edema (Swelling)
Hypertension
Rheumatic Fever
Murmur

GI
Nausea
Vomiting
Diarrhea
Jaundice
Blood in Stool
Constipation

NEURO
Headache
Stroke
Paralysis
Numbness
Pain
Hallucinations
Nervous Breakdown
Loss of Consciousness