Office Use Only

MRN: ______________

BAPTIST ENDOCRINOLOGY MANDARIN

PATIENT NAME: ________________________________ DOB: ______________ APPT DATE: ______________

PRIMARY CARE DR.: ______________________________ FORMER ENDOCRINOLOGIST: ______________________

PHARMACY NAME/LOCATION: ______________________________ PHARMACY NUMBER: ________________

CHIEF COMPLAINTS *Please check the box if you are experiencing any of these symptoms.*

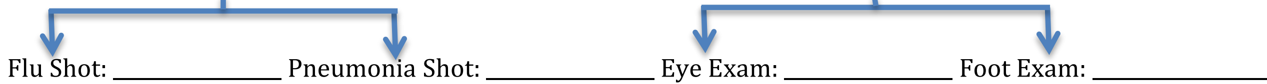
☐ Nausea
☐ Diarrhea
☐ Constipation
☐ Urinary Complaints
☐ Weight Loss ______ (amt)
☐ Weight Gain ______ (amt)
☐ Fast Heart Beat/Fluttering
☐ Shortness of Breath
☐ Fatigue

☐ Fractured Bones
☐ Thyroid Problems
☐ Pain or Pressure in Chest
☐ Dizziness or Fainting
☐ Frequent or Severe Headaches
☐ Numbness/Tingling
☐ Seizures
☐ Blurry Vision
☐ Skin Problems/Rashes

☐ Sleep Problems
☐ Fertility Issues
☐ Sexual Problems
☐ Mood Changes
☐ Hair Loss/Hair Growth
☐ Snoring
☐ Cancer

When Was Your Last:

If You're Diabetic, When Was Your Last:



Flu Shot: ____________ Pneumonia Shot: ____________ Eye Exam: ____________ Foot Exam: ____________

SOCIAL HISTORY

Marital Status: ☐S ☐M ☐W ☐D # of Children: ________ Tobacco Use: ☐ No ☐ Yes ____ Pack Per Day ____Years

Alcohol Use: ☐ Social ☐ Heavy ☐ None Employment: ☐ None ☐ Full-Time ☐ Part-Time ☐Retired Where?:___________

PAST MEDICAL HISTORY *Diagnosis and year you were diagnosed *Example – "Hypothyroidism" Diagnosed in "1997".*

DIAGNOSIS	YEAR	DIAGNOSIS	YEAR

PAST SURGICAL HISTORY

SURGERY	YEAR	SURGERY	YEAR

FAMILY HISTORY *Please check & list which **1st degree relative (mom/dad, sibling, child)** was diagnosed with the disease.*

☐ Diabetes: ______________________________
☐ Obesity: ______________________________
☐ Thyroid Disease: ______________________________
☐ High Cholesterol: ______________________________

☐ Auto Immune Disease: ______________________________
☐ Early Heart Disease: ______________________________
☐ Cancer (What kind? Who?): ______________________________
☐ Other: ______________________________

ALLERGIES *If you are allergic to any medication, please list below and explain your reaction to it.*

____

MEDICATIONS *Please list **ALL** medication you're taking here or provide us with a list. Make sure to include the dose and what you take the medication for. Also please list all over-the-counter (OTC) medications, vitamins, and supplements.*

MEDICATION	DOSE	INDICATION	MEDICATION	DOSE	INDICATION

Signature of Patient: ______________________________________ Date: ______________

Physician Reviewed: ______________________________________ Date: ______________