Tel 678-679-6210
3340 Paddocks Parkway

Fax 678-679-6220
Suwanee, GA 30024

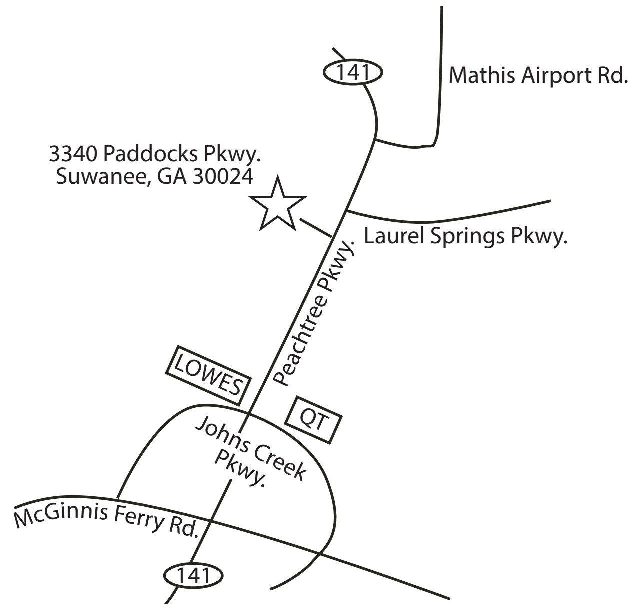
Welcome to John's Creek Specialist Center

We at John's Creek Specialist Center are committed to excellence in healthcare. Our well-trained team is focused on providing a high standard of care in a warm, efficient office environment. We realize that you have a choice regarding your medical care. We appreciate and value your business, and we will strive to do everything we can to provide you with the personalized service you deserve.

Directions

John's Creek Specialist Center is located at 3340 Paddocks Parkway in Suwanee. If this map does not help you with your route to our office, and if you have Internet access, just go to http://maps.google.com, and you can create custom turn-by-turn directions from your location.

If you do not have access to the Internet, or if the resulting directions are not helpful to you, just call our office at 678-679-6210, and we'll be glad to help you with directions.



New patient forms

Please print the forms, fill them out by hand, and bring them with you at the time of your visit.

Thank you for your help!

NEPH 08-11

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DIRECTIONS

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New Endocrinology Patient Medical History

Personal information

Date of first appointment ______ Time of appointment ______

Last name ______ First name ______

Middle name or initial ______ Maiden name ______

Street (mailing) address ______

City ______ State ______ Zip ______

Birthplace ______ Birthdate ______ Sex ☐ female ☐ male

Marital status ☐ never married ☐ married ☐ divorced ☐ separated ☐ widowed

Spouse/significant other ☐ alive age ______ ☐ deceased at age ______

Spouse's or significant other's major illnesses ______

Education ______

Grade school ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 College ☐ 1 ☐ 2 ☐ 3 ☐ 4

Graduate school? ☐ yes ☐ no If "yes," school name ______

Referral

Referred by ☐ self ☐ family ☐ friend ☐ doctor ☐ other health professional

If other than "self," name of person who referred you ______

Purpose of visit

Describe your present symptoms ______

______

______

Surgeries and hospitalizations

Type	Year	Reason

NEPH 08-11

Patient's name ______ *Date* ______ *Physician's initials* ______

Medicines, vitamins, supplements, herbs

Name (example: Lipitor)	Dose (example: 10 mg)	Frequency (example: once a day)

I am *allergic* to these medications/foods/dyes

Diabetes/elevated glucose patients *only*

Date of last diabetic eye exam	month	year
Date of last podiatry/foot exam	month	year
Date of last dental exam	month	year
Date of last nutritionist/diabetes educator visit	month	year

Do your *parents/siblings/children* have (or had)...

Heart attack/heart bypass surgery/stent	☐ don't know	☐ yes	☐ no	Age?
Stroke	☐ don't know	☐ yes	☐ no	
High cholesterol	☐ don't know	☐ yes	☐ no	
Obesity	☐ don't know	☐ yes	☐ no	
Adult diabetes	☐ don't know	☐ yes	☐ no	
Juvenile, Type 1 diabetes	☐ don't know	☐ yes	☐ no	
Thyroid disease	☐ don't know	☐ yes	☐ no	What kind?
Cancer	☐ don't know	☐ yes	☐ no	Where did it start?
Osteoporosis, hip fracture	☐ don't know	☐ yes	☐ no	Age?
Rheumatoid arthritis, lupus, multiple sclerosis?	☐ don't know	☐ yes	☐ no	

Patient's name *Date* *Physician's initials*

Please mark any of the following symptoms that you are experiencing.

General

- ☐ unexplained rapid weight gain
- ☐ fever
- ☐ unexplained rapid weight loss
- ☐ extreme tiredness

Endocrine

- ☐ excessive sweating/night sweats
- ☐ low blood sugar
- ☐ calcium problems
- ☐ potassium problems
- ☐ heat/cold intolerance
- ☐ adrenal problems
- ☐ thyroid problems
- ☐ pituitary problems

Eyes

- ☐ eye laser treatments
- ☐ glaucoma
- ☐ poor vision/blindness
- ☐ macular degeneration
- ☐ tunnel vision (poor peripheral vision)
- ☐ double vision
- ☐ color blindness
- ☐ retinal detachment

ENT

- ☐ loss of hearing/deafness
- ☐ dentures/bridges
- ☐ mouth dryness
- ☐ difficulty swallowing
- ☐ changes in voice, hoarseness
- ☐ pain in front of the neck
- ☐ enlarged thyroid or neck lumps
- ☐ impaired smell or taste

Heart/lungs

- ☐ use oxygen
- ☐ sleep apnea, use CPCP/BiPAP
- ☐ shortness of breath on exertion
- ☐ pacemaker or internal defibrillator
- ☐ blood in sputum
- ☐ short of breath at night/rest
- ☐ chest/arm/jaw discomfort on exertion
- ☐ asthma or COPD
- ☐ slow, fast or irregular heart beat
- ☐ long term cough
- ☐ ankle/leg swelling with water
- ☐ calf pain while walking

Breast

- ☐ nipple discharge
- ☐ breast lump/mass
- ☐ breast pain/tenderness or swelling

Gastrointestinal

- ☐ nausea
- ☐ vomiting
- ☐ early satiety
- ☐ eating disorder
- ☐ diarrhea
- ☐ constipation
- ☐ irritable bowel
- ☐ crohn's disease or colitis
- ☐ frequent heartburn, indigestion
- ☐ abdominal pain
- ☐ bloody or black, tarry stools
- ☐ food intolerances

Blood

- ☐ history of blood clots
- ☐ bleeding problems
- ☐ easy bruising
- ☐ anemia
- ☐ radiation treatments to head, neck or whole body

Urological

- ☐ frequent bladder or vaginal infections
- ☐ kidney problems
- ☐ kidney stones
- ☐ frequent urination

Men only

- ☐ pain or lump in testicles
- ☐ STD/discharge
- ☐ difficulty achieving/maintaining erections
- ☐ change in desire to have sexual intimacy (libido)

Patient's name ________________________ *Date* __________ *Physician's initials* __________

Women only

☐ date of last period ☐ irregular periods ☐ spotting between periods

☐ pregnant now Number of pregnancies Number of live births

☐ contraception use (birth pill, iuds, condoms, vasectomy)

Muscle/bones

☐ muscle aches ☐ muscle weakness ☐ gout

☐ arthritis ☐ fractures ☐ amputations

Skin

☐ foot/leg ulcers ☐ skin rash ☐ darkening or lightening of the skin

☐ dry skin ☐ hair loss ☐ brittle nails

Neuro/psych

☐ frequent severe headaches ☐ dizziness ☐ previous head injury

☐ unsteady gait ☐ seizures ☐ loss of consciousness

☐ paralysis ☐ tremor ☐ burning, shooting pain in hands/feet

☐ decreased sensation/feet ☐ memory loss ☐ depression/anxiety/fears

Anything else you would like us to know about you?

Patient's name *Date* *Physician's initials*

ENDOCRINOLOGY MEDICAL HISTORY FORM