Please complete the following questions so your doctor will have a record of your past and present medical history.

Patient Name: ______________________ Date of Birth: ____________ Today's Date: ____________

Reason for Current Visit: ____

Referring Physician: ______________________ Phone: ____________ Fax: ____________

Primary Care Physician: ______________________ Phone: ____________ Fax: ____________

Specialist Physician you see: ______________________ Phone: ____________ Fax: ____________

Specialist Physician you see: ______________________ Phone: ____________ Fax: ____________

Specialist Physician you see: ______________________ Phone: ____________ Fax: ____________

Women:

Are you currently pregnant? Yes ☐ No ☐ N/A ☐ If so, how many weeks? __________ LMP__________

Men:

Date of last Prostate Exam ____________________

PAST SURGICAL HISTORY: Please circle all that apply and date of surgery

No Surgical History ____________________

Cardiac Bypass Surgery ____________________

Stent/Angioplasty ____________________

Thyroidectomy ____________________

Gastric Bypass ____________________

Pituitary Surgery ____________________

Hysterectomy ____________________

Other: ____________________

if so when ____________________

VACCINATION HISTORY:

Influenza (YES or NO) ____________________ Date of last vaccination: ____________________

Pneumonia (YES or NO) ____________________ Date of last vaccination: ____________________

COVID-19 (YES or NO) ____________________ Date of last vaccination: ____________________

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ENDOCRINOLOGY PATIENT INTAKE FORM

Patient Name ______________________________

Date of Birth _____ /_____ /________
Month Day Year

MEDICAL HISTORY: Please circle all that apply

Depression
Diabetes Type I
Diabetes Type II
Hyperlipidemia (High Cholesterol)
Hypertension (High Blood Pressure)
Hyperthyroidism
Hypothyroidism
Hypocalcemia (Low Calcium)
Hypercalcemia (High Calcium)
Pituitary tumors
Thyroid Disorder
Acromegaly
Anemia
Anxiety
Asthma
Autoimmune Disorder

CHF
COPD
Coronary Artery Disease
Crohn's Disease
Cushing's Disease
GERD
HIV
Kidney Stone
Cirrhosis
Hepatitis ________
Low Testosterone
Osteopenia
Osteoporosis
PCOS
Rheumatoid arthritis
Adrenal Disorder

Seizure Disorder
Stroke
TIA
Cancer - Breast
Cancer - Cervical
Cancer - Colon
Cancer-Prostate
Cancer-Thyroid
Cancer other- ________________
Osteoarthritis
Other: ______________________
____
____
Seasonal Allergies

NORTH GEORGIA
DIABETES AND
ENDOCRINOLOGY

Patient Name ______________________________
Date of Birth _____ /_____ /________
Month Day Year

FAMILY HISTORY: Please circle all that apply

I am adopted	yes				
Diabetes	Mother	Father	Both Parents	Brother	Sister
Thyroid Disease	Mother	Father	Both Parents	Brother	Sister
Thyroid Nodules	Mother	Father	Both Parents	Brother	Sister
Hyperthyroidism	Mother	Father	Both Parents	Brother	Sister
Hypothyroidism	Mother	Father	Both Parents	Brother	Sister
Blood Clots	Mother	Father	Both Parents	Brother	Sister
Depression	Mother	Father	Both Parents	Brother	Sister
Headaches	Mother	Father	Both Parents	Brother	Sister
Heart disease	Mother	Father	Both Parents	Brother	Sister
Hypertension	Mother	Father	Both Parents	Brother	Sister
High Cholesterol	Mother	Father	Both Parents	Brother	Sister
Osteoporosis	Mother	Father	Both Parents	Brother	Sister
Seizures	Mother	Father	Both Parents	Brother	Sister
Cancer: _______________	Mother	Father	Both Parents	Brother	Sister
Other: _________________					

Glucose Monitored: YES ☐ NO ☐ Type of Glucometer: ____________________________________

Dietary Changes: Low Fat ☐ Low Salt ☐ Counting Carbs ☐ Weight Reduction ☐ Diet ☐ Other: ____________

Do you exercise regularly? YES ☐ NO ☐ How many times per week? ____________________________

Types of exercise: _________________________ _________________________ _________________________

SOCIAL HISTORY: please circle all that apply:

Single Married Widowed Divorced Separated

Occupation: ____ Education: _______________________

Patient Name ______________________________
Date of Birth _____ /_____ /________
Month Day Year

RISK FACTORS:

Do you use tobacco? YES ☐ QUIT: __________________ (year) NEVER ☐

If currently smoking cigarettes, how many packs per day? _______________

If currently smoking cigars, how many per week? ______________________

Other Forms of tobacco YES ☐ NO ☐ _________________________

Do you drink alcohol? YES ☐ NO ☐ How many drinks per day? ________________

Do you drink Caffeine? YES ☐ NO ☐ How many caffeinated beverages per day? _______________

MEDICATIONS: List all medications you are currently taking:

MEDICATION	DOSE	HOW OFTEN

ALLERGIES: List medication allergies and reactions (Hives, Swelling, ETC.)

____

____

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ENDOCRINOLOGY PATIENT INTAKE FORM