NORTH GEORGIA
DIABETES AND
ENDOCRINOLOGY

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: _____

NORTH GEORGIA
DIABETES AND
ENDOCRINOLOGY

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

1400 Northside Forsyth Drive, Suite 310 • Cumming, GA 30041 • Phone: 770-886-3842 • Fax: 770-886-3843
3350 Paddocks Parkway • Suwanee, GA 30024 • Phone: 678-735-5300 • Fax: 678-735-5305

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: _____

1400 Northside Forsyth Drive, Suite 310 • Cumming, GA 30041 • Phone: 770-886-3842 • Fax: 770-886-3843
3350 Paddocks Parkway • Suwanee, GA 30024 • Phone: 678-735-5300 • Fax: 678-735-5305

NORTH GEORGIA
DIABETES AND
ENDOCRINOLOGY

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.)

_____

_____

NORTH GEORGIA
DIABETES AND
ENDOCRINOLOGY

Patient Name: _____ Date of Birth _____

GENERAL

Weight loss	☐ Yes	☐ No
Weight gain	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

EYE

Loss of vision	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Bulging eyes	☐ Yes	☐ No
Dry eyes	☐ Yes	☐ No

ENT

Persistent hoarseness	☐ Yes	☐ No
Sinus Congestion	☐ Yes	☐ No

CARDIAC

Chest pain or pressure	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No

LUNGS

Shortness of breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

DERMATOLOGY

Excessive dry skin	☐ Yes	☐ No
Excessive hair growth	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Vitilgo	☐ Yes	☐ No
Skin ulcer	☐ Yes	☐ No

NEUROLOGIC

Tremor	☐ Yes	☐ No
Frequent headache	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Burning pain in feet	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

PSYCHIATRIC

Depression	☐ Yes	☐ No
Sleep disturbances	☐ Yes	☐ No
Eating disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No

ENDOCRINOLOGY

Excessive thirst	☐ Yes	☐ No
Sensitive to cold temperature	☐ Yes	☐ No
Sensitive to hot temperature	☐ Yes	☐ No
Urination at night	☐ Yes	☐ No
Breast growth (men)	☐ Yes	☐ No
Breast discharge	☐ Yes	☐ No

GASTROINTESTINAL

Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No

NORTH GEORGIA
DIABETES AND
ENDOCRINOLOGY

Patient Name: _____ Date of Birth _____

URINARY

Difficulty urinating	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No
Nocturia	☐ Yes	☐ No
Poor libido	☐ Yes	☐ No

GYNECOLOGICAL

Last menstrual period?_____

Number of pregnancies	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
Number of miscarriages	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
Number of live births	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
How many greater than 9 lbs?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Irregular Periods	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No

MUSCULOSKELETAL

Joint stiffness	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Muscle cramping	☐ Yes	☐ No
Fracture	☐ Yes	☐ No