NORTH GEORGIA
DIABETES AND ENDOCRINOLOGY
www.northgeorgiaendocrine.com

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ENDOCRINOLOGY PATIENT INTAKE FORM

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: _____

Are you currently pregnant?_____ If so, how many weeks?_____

PAST MEDICAL HSITORY: **Please circle all that apply**

Depression	CHF	Seizure Disorder
Diabetes Type I	COPD	Stroke
Diabetes Type II	Coronary Artery Disease	TIA
Hyperlipidemia (High Cholesterol)	Crohn's Disease	Cancer - Breast
Hypertension (High Blood Pressure)	Cushing's Disease	Cancer - Cervical
Hyperthyroidism	GERD	Cancer - Colon
Hypothyroidism	HIV	Cancer-Prostate
Hypocalcemia	Kidney Stone	Cancer-Thyroid
Hypercalcemia	Cirrhosis	Cancer other- _____
Pituitary tumors	Hepatitis _____	Osteoarthritis
Thyroid Disorder	Low Testosterone	Other: _____
Acromegaly	Osteopenia	_____
Anemia	Osteoporosis	_____
Anxiety	PCOS	_____
Asthma	Rheumatoid arthritis	
Autoimmune Disorder	Seasonal Allergies	

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Patient Name: _____

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

Bypass Surgery _____	Anesthesia Problems	YES	NO
Pacemaker/Defibrillator _____	Surgical Complications	YES	NO
Stent/Angioplasty _____	Post Op Delirium	YES	NO
Thyroidectomy _____	Other:_____		
Gastric Bypass _____	if so when_____		

FAMILY HISTORY: Please circle all that apply

I am adopted	yes		Both Parents	Brother	Sister
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
Alcoholism	Mother	Father	Both Parents	Brother	Sister
Anemia	Mother	Father	Both Parents	Brother	Sister
Arthritis	Mother	Father	Both Parents	Brother	Sister
Anxiety	Mother	Father	Both Parents	Brother	Sister
Asthma	Mother	Father	Both Parents	Brother	Sister
Blood Clots	Mother	Father	Both Parents	Brother	Sister
Depression	Mother	Father	Both Parents	Brother	Sister
Growth Develop/Disorder	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			

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Patient Name: _____

Glucose Monitored: YES NO If yes, last reading; _____

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: _____

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? _____

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.)

_____

_____