CREEDMOOR CENTRE
ENDOCRINOLOGY
WHERE IT ALL COMES TOGETHER

Today's Date:_____

Patient Name: _____

Preferred Name: _____Preferred pronoun: _____

Date of Birth: _____ Cell Phone: _____

Email address: _____

Home Phone: _____ Work Phone: _____Ext_____

Preferred Contact Method: Home Phone ☐ Cell ☐ Work phone ☐ Email ☐ US Mail ☐

Address_____Apt_____City_____Zip_____

Primary MD: _____Name of office: _____

Referring MD: _____Name of office: _____

Sex: M ☐ F ☐ Other _____Gender Assigned at Birth: M ☐ F ☐

Gender Identity _____

Race: Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other_____

Language Spoken at Home: _____

Is patient under 18? No ☐ Yes ☐, If yes, please complete box below:

Name(s) of Parent(s) or Legal Guardian (paperwork must be presented):

_____

First Last

Email address: _____Cell phone: _____

Reason for visit: *If Diabetes, please complete the Diabetes information below.

_____

_____

Diabetes Type: Type 1 ☐ Type 2 ☐ Gestational ☐ Other_____

Date Diagnosed: _____Hospitalized at Diagnosis? No ☐ Yes → in DKA? No ☐ Yes ☐

Most recent Diabetes Education visit: _____

Details of Insulin Therapy

Insulin(s) currently using: Humalog ☐ Novolog ☐ Apidra ☐ U-500 ☐ Afrezza ☐ 50/50 ☐

Lantus ☐ Levemir ☐ Toujeo ☐ Tresiba ☐ Basaglar ☐ NPH ☐ Regular ☐ 70/30 ☐

Lyumjev ☐ Fiasp ☐

Mode of therapy: Inhaled ☐ Shots ☐

Pump, which one? _____ Start Date?_____

Testing Regimen: Meter: _____Tests/day: _____

Continuous Glucose Sensor_____

Medical History

Ongoing medical problems: (example: Diabetes, High Blood Pressure, etc.)

_____

_____

Allergy/Reaction: (example: Penicillin/Rash) No known drug allergies _____

_____

_____

Women: Pregnancies (#):_____ Live births(#):_____Miscarriages (#): _____

Are you pregnant? No ☐ Yes ☐ Due Date_____

Men: Have you fathered children? No ☐ Yes ☐

Family History:

Relation	Birth Year	Age at Death	Health Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Do any Blood Relatives have? Diabetes ☐ Thyroid condition ☐ Cancer ☐ Osteoporosis

☐ Pituitary problem ☐ Heart Disease or Stroke

Surgical History: **None** ☐

Year	**Procedure**

Hospitalizations: **None** ☐ **Childbirth** ☐ **Surgeries Only** ☐

Year	**Reason**

Exercise: No ☐ Yes→ How many minutes per day? _____How many days per week? _____

Hours of sleep per night? _____

Recreational Substance Use:

	Ever Used?	Current use?	Quit date?	How much?	How often?
Tobacco	Yes ◯ No ◯	Yes ◯ No ◯			
Street Drugs	Yes ◯ No ◯	Yes ◯ No ◯			

Alcohol Use

Any alcohol use in the past year? If yes, please answer the following:

How many drinks per day? _____

How many drinks per week? _____

How many drinks per year? _____

Social history:

Marital Status: _____Occupation: _____

Last Completed or Current Grade in school: _____

Preferred Pharmacy Name_____

Street _____City_____Zip_____

and/or phone: _____

Current Medications and Dosing (please include vitamins and supplements)

Medication	Dose	Start Date