CREEDMOOR CENTRE ENDOCRINOLOGY
WHERE IT ALL COMES TOGETHER

New Patient Form

Demographic Data: **Today's Date:**_____

Patient Name:_____Preferred Name:_____Preferred pronoun:_____
First Last

Date of Birth:_____ Cell Phone:_____Email address:_____

Sex: ○ M ○ F ○Other Gender Assigned at Birth: ○ M ○ F

Race: ○White ○African-American ○Hispanic ○Asian ○Other_____ Language Spoken at Home:_____

Is patient under age of 18? ○No ○ Yes, Please complete box below:

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

_____
First Last

Email address:_____Cell phone_____

Home phone:_____ Work Phone:_____Ext_____

Preferred Contact: ○ Home Ph ○Cell ○Work ph ○Email ○US Mail

Address_____Apt_____City_____Zip_____

Primary MD:_____Name of office:_____

Referring MD:_____Name of office:_____

Reason for visit: *If Diabetes, please STOP and complete New Diabetes Patient Intake Form

_____

Past Medical History:

Major events, hospitalizations, surgeries:_____

_____

Women: Pregnancies(#):____ Live births(#):____Miscarriages (#): ____Are you pregnant? ○No ○Yes, Due Date___

Men: Have you fathered children? ○No ○ Yes

Allergy/Reaction: (example: Penicillin/Rash)_____

_____

Ongoing medical problems:_____

_____

_____

_____

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Patient Name:_____
First Last

Family History:

Relation	State of Health	Age at Death	Health Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Do any Blood Relatives have:

○Type I Diabetes ○Type II Diabetes ○Thyroid condition ○Cancer ○Osteoporosis ○PCOS ○Pituitary problem

○Heart Disease or Stroke ○High Cholesterol ○ Other Endocrine problems_____

Preventive care:

Exercise: ○No ○Yes→ How many minutes/day?_____How many days/week?_____ Hours of sleep/ night?_____

Contraceptive used_____Last menstrual period: _____ Last PAP smear:_____

Last mammogram:_____ Last colonoscopy:_____Are your immunizations up to date? ○Yes ○ No

Social history:

Marital Status: _____Occupation:_____Last completed or Current Grade in school:_____

Recreational Substance Use:

	Ever Used?	Current use?	Quit date?	How much?	How often?
Tobacco					
Alcohol					
Street Drugs					
Other					

Preferred Pharmacy Name_____ Street_____City_____Zip_____,

and/or phone:_____

Current Medications and Dosing (please include vitamins and supplements)

_____

_____

_____

_____

_____

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GENERAL
- Fever or chills
- Night Sweats
- Change in appetite
- Fatigue
- Fainting
- Poor sleep
- Unexplained weight loss
- Weight gain
- Recent trauma
- Lumps or bumps
- Unexplained falls

MUSCULOSKELETAL
- Joint pain
- Joint stiffness
- Joint swelling
- Noisy joints
- Arthritis
- Joint deformities

GENITOURINARY
- Frequent urination
- Blood in urine
- Painful urination
- Lack of bladder control
- Urinating at night
- Urinating more volume than expected

NEUROLOGICAL
- Headaches
- Seizures
- Confusion
- Difficulty with balance
- Difficulty with speech
- Numbness
- Tingling
- Dizziness

EYE
- Visual changes
- Eye pain
- Blurred vision
- Double vision
- Blind spots
- "floaters"

GASTROINTESTINAL
- Abdominal Pain
- Cramping
- Food avoidance
- Bloating
- Indigestion
- Heartburn
- Nausea
- Vomiting
- Constipation
- Diarrhea
- Vomiting blood
- Red blood in stool
- Black stools

SKIN/BREAST
- Itching
- Hives
- Rash
- Sore that won't heal
- Stretch marks
- Dark, thick skin at back of neck
- Eczema
- Change in moles
- Acne
- Dry Skin
- Breast pain
- Breast lumps
- Breast discharge

RESPIRATORY
- Cough
- Wheezing
- Coughing up blood/mucus
- Shortness of breath

CARDIOVASCULAR
- Chest pain
- Hard to exercise
- Waking up gasping for air
- Can't sleep flat
- Palpitations
- Rapid heart beat
- Pain in legs with walking
- Swollen ankles

EAR, NOSE, MOUTH, THROAT
- Runny nose
- Ringing in ears
- Toothache
- Sore throat
- Ear ache
- Hearing loss
- Sinus problems
- Nosebleeds
- Bleeding gums
- Difficulty swallowing
- Hoarseness
- Painful swallowing

ENDOCRINE
- Cold Intolerance
- Heat Intolerance
- Excess hunger
- Excess thirst
- Excessive hair growth
- Hair loss
- Unexplained tanning

ALLERGIC/ IMMUNOLOGIC
- Anaphylaxis
- Lymph node swelling
- Allergic reactions

PSYCHIATRIC
- Depression
- Anxiety
- Crying Spells
- Decreased work or school performance
- Personality change
- Mood swings

HEMATOLOGIC
- Anemia
- Bruising
- Unexpected bleeding
- History of blood transfusion
- Refused for blood donation

MEN ONLY
- Erection difficulties
- Poor sex drive
- Lump in testicles
- Penis discharge

WOMEN ONLY
- Abnormal PAP
- Painful periods
- Spotting
- Irregular periods
- Vaginal Discharge
- Hot flashes
- Painful intercourse
- Poor sex drive