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: ☐ Caucasian ☐ 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 Phone Cell __ Work phone Email US Mail

Address_____Apt_____City_____Zip_____

Primary MD: _____Name of office:_____

Referring MD: _____Name of office:_____

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

Mode of therapy: ☐ Inhaled ☐ Insulin/Vial Insulin/Pens

Pump, which one? _____ Start Date?_____

Testing Regimen: Meter:_____Tests/day:_____

Continuous Glucose Sensor_____

Date of last eye exam Date of last foot exam

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:_____

_____

_____

_____

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 per day? _____How many days per week?_____

Hours of sleep per night?_____

Contraceptive used _____Last menstrual period: _____ Last PAP smear:_____

Last mammogram:_____ Last colonoscopy: _____

Are your immunizations up to date? ☐ Yes ☐ No

Marital Status: Single 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)

_____

_____

_____

_____

_____

Upon completion, please click the "Submit Form" button below. Your form will be added to an email message for submission to our practice. Thank you for taking the time to complete this form prior to your arrival for your appointment.

Submit Form