CREEDMOOR CENTRE
ENDOCRINOLOGY
WHERE IT ALL COMES TOGETHER

Today's Date:____________________

Patient Name (Last, First): ____

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 age of 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

Preventive care:

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					
Street Drugs					

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