Pennsylvania Institute of Endocrinology - **New Patient Form** (Type or print clearly, fill the bubbles in black color)

Patient Name: Write below (Last Name, First Name, Middle Initial)	
Patient Name:	
Date of Birth: (Month/Day/Year)	
Address:	
Home Telephone:	**Cell Telephone:**
Work Telephone:	**Other Telephone:**
E-mail	**Social Security#**
Emergency Contact:	
Relationship to Patient:	**Emergency Contact Telephone:**
Sex: ◯ Male ◯ Female	
Race: ◯ Black ◯ Hispanic ◯ Asian ◯ White ◯ Native American ◯ Other	
Primary Language Spoken	
Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Other	
Employer:	
Referring physician:	**Ph:**
Address:	**Fax:**
Primary Care Physician:	
Primary Insurance:	
ID#	**Group #**
Subscriber Name & Date of Birth:	
Relationship to Patient:	
Secondary Insurance:	
ID#	**Group #**
Subscriber Name	**Date of Birth:**
Relationship to Patient:	
Name of Pharmacy (Local)	**Fax**
Address	
City **State**	**Zip Code**
Name of Pharmacy (Mail Order)	
Address	
Primary Medical Reason For This Visit?	

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List current medications or Attach list	Dosage	How often, you take medicine?

Name of Glucometer (If you have Diabetes)	
Past Surgeries:	**Date: (Month and Year)**
Allergies to Medications:	**Reaction:**

Have you been hospitalized in the past year? ◯**YES** ◯**NO**

If yes, when and reason for hospitalization?

Do you drink alcohol: ◯**YES** ◯**NO** **How many times per month**

How many drinks at one time typically you take? (fill bubble below)

◯**1-3 drinks** ◯**3-5 drinks** ◯**5 or More drinks**

How often 6 or more drinks at one stretch over last year

Are you current smoker ◯**YES** ◯**NO**

If yes how many cigarettes per day

How many minutes after waking up you smoke 1st cigarette

Do you want to quit ◯**YES** ◯**NO**

Are you a former smoker ◯**YES** ◯**NO**

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Bubble Sheet 1

Patient Name: _____ DOB : _____ DATE: _____

Who among these have type 1 Diabetes?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have type 2 Diabetes?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have high blood Pressure?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have high cholesterol?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who these have heart disease?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have thyroid disease?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have osteoporosis (week bones)?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have high calcium?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Who among these have cancer?

◯ father ◯ mother ◯ sibling ◯ child
◯ grandparent ◯ other relative ◯ none

Please list any other significant medical problem in your family (Not mentioned in the form):

_____
_____
_____
_____
_____

Do you have any of the following?

Diabetes, type I	◯ Yes	◯ No
Diabetes, type II	◯ Yes	◯ No
Hypertension	◯ Yes	◯ No
Hyperlipidemia	◯ Yes	◯ No
Coronary artery disease	◯ Yes	◯ No
Hypothyroidism	◯ Yes	◯ No
Hyperthyroidism	◯ Yes	◯ No
Thyroid nodule	◯ Yes	◯ No
Osteoporosis	◯ Yes	◯ No

Please list any other significant medical problem that you have (Not mentioned above):

_____
_____
_____
_____
_____

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Bubble Sheet 2

General/Constitutional

Change in appetite	◯ Yes	◯ No
Fatigue	◯ Yes	◯ No
Fever	◯ Yes	◯ No
Sleep disturbance	◯ Yes	◯ No
Weight gain	◯ Yes	◯ No
Weight loss	◯ Yes	◯ No

Ophthalmologic

Proptosis (Swelling of eyes)	◯ Yes	◯ No
diplopia (Double Vision)	◯ Yes	◯ No
Blurred vision	◯ Yes	◯ No
Dry eye	◯ Yes	◯ No
Pain	◯ Yes	◯ No
Itching and redness	◯ Yes	◯ No

ENT

Decreased hearing	◯ Yes	◯ No
Decreased sense of smell	◯ Yes	◯ No
Difficulty swallowing	◯ Yes	◯ No
Dry mouth	◯ Yes	◯ No
Sinus pain	◯ Yes	◯ No
Sore throat	◯ Yes	◯ No

Endocrine

Cold intolerance	◯ Yes	◯ No
Excessive sweating	◯ Yes	◯ No
Excessive thirst	◯ Yes	◯ No
Frequent urination	◯ Yes	◯ No
Heat intolerance	◯ Yes	◯ No
Weakness	◯ Yes	◯ No

Respiratory

Cough	◯ Yes	◯ No
Shortness of breath with exertion	◯ Yes	◯ No
Shortness of breath at rest	◯ Yes	◯ No
Wheezing	◯ Yes	◯ No

Cardiovascular

Chest pain at rest	◯ Yes	◯ No
Chest pain with exertion	◯ Yes	◯ No
Claudication	◯ Yes	◯ No
Fluid accumulation in the legs	◯ Yes	◯ No
Irregular heartbeat	◯ Yes	◯ No
Palpitations	◯ Yes	◯ No
Orthopnea (Shortness of breath on lying)	◯ Yes	◯ No

Gastrointestinal

Abdominal pain	◯ Yes	◯ No
Constipation	◯ Yes	◯ No
Diarrhea	◯ Yes	◯ No
Heartburn	◯ Yes	◯ No
Nausea	◯ Yes	◯ No
Vomiting	◯ Yes	◯ No

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Bubble Sheet 3

Hematology

Easy bruising	◯ Yes	◯ No
Prolonged bleeding	◯ Yes	◯ No

Women Only

Menopause	◯ Yes	◯ No
Discharge from the breast	◯ Yes	◯ No
Heavy bleeding during menses	◯ Yes	◯ No
Hot flashes	◯ Yes	◯ No
Irregular menses	◯ Yes	◯ No
Painful menses	◯ Yes	◯ No
Vaginal discharge/itching	◯ Yes	◯ No

Men Only

erectile dysfunction	◯ Yes	◯ No
Difficulty initiating stream	◯ Yes	◯ No
Scrotal swelling	◯ Yes	◯ No
Undescended testicle	◯ Yes	◯ No

Genitourinary

Blood in urine	◯ Yes	◯ No
Difficulty urinating	◯ Yes	◯ No
Frequent urination	◯ Yes	◯ No

Musculoskeletal

Joint stiffness	◯ Yes	◯ No
Leg cramps	◯ Yes	◯ No
Muscle aches	◯ Yes	◯ No
Painful joints	◯ Yes	◯ No
back pain	◯ Yes	◯ No

Skin

Acne	◯ Yes	◯ No
Hypopigmentation	◯ Yes	◯ No
Dry skin	◯ Yes	◯ No
Itching	◯ Yes	◯ No
Rash	◯ Yes	◯ No
Hyperpigmentation	◯ Yes	◯ No

Neurologic

Balance difficulty	◯ Yes	◯ No
Dizziness	◯ Yes	◯ No
Fainting	◯ Yes	◯ No
Gait abnormality	◯ Yes	◯ No
Headache	◯ Yes	◯ No
Tingling/Numbness	◯ Yes	◯ No
Tremor	◯ Yes	◯ No

Psychiatric

Anxiety	◯ Yes	◯ No
Hallucinations (Hearing or seeing non-existent things)	◯ Yes	◯ No
Delusions	◯ Yes	◯ No
Depressed mood	◯ Yes	◯ No
Stressors	◯ Yes	◯ No
Suicidal thoughts	◯ Yes	◯ No