

BAPTIST ENDOCRINOLOGY

Patient Name: _____ Date: _____ PCP: _____

Referred By: _____ Pharmacy: _____ Phone: _____

List of complaints: *Please circle if you are experiencing any of these symptoms:*

- | | | |
|----------------------------|---------------------|-----------------------|
| Nausea | Fatigue | Blurred Vision |
| Constipation/Diarrhea | Fractured Bones | Skin Problems |
| Urinary Complaints | Thyroid Problems | Sleep Problems |
| Weight Gain | Chest Pain/Pressure | Fertility Issues |
| Weight Loss | Dizziness/Fainting | Sexual Problems |
| Fast Heart Beat/Fluttering | Headaches | Mood Changes |
| Shortness of Breath | Seizures | Hair Loss/Hair Growth |
| Snoring/Sleep Problems | Numbness/Tingling | Cancer |

Last Eye Exam: _____ Last Flu Shot: _____ Last Pneumonia Shot: _____

Last Foot Exam: _____ Marital Status(circle): SMWD # Children _____

Tobacco Use: no yes _____ Pk Per Day _____ Yrs Alcohol Use: Social Heavy None

Employment Status: None Full-Time Part-Time Retired

Past Surgeries/Medical Problems

Year

Past Surgeries/Medical Problems	Year

Family History (please circle if yes): Diabetes Obesity Thyroid Disease/Cancer
High Cholesterol Issues Auto Immune Disease Early Heart Disease Other: _____

Allergies – medication and reaction: _____

Please list **all** your medications including over-the-counter medications:

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NAME: _____ DOB: _____ DATE: _____

Do you need refills on any medications prescribed by the physicians here?

Which ones: _____

CONCERNS: _____

OFFICE USE ONLY

URINALYSIS:

COLOR: _____

CLARITY: _____

LEUKOCYTES: _____

NITRITE: _____

UROBILI: _____

PROTEIN: _____

PH: _____

BLOOD: _____

SPEC GRAVITY: _____

KETONES: _____

BILIRUBIN: _____

GLUCOSE: _____

Height: _____

Temp: _____

B/P: _____

Pulse: _____

Resp: _____

Weight: _____ Change: _____

Waist: _____ Change: _____

HCG: + -

GLUCOSE BY GLMTR: _____

HgbA1C: _____