EUGENE ENDOCRINOLOGY

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Thank you for allowing us to become partners in your Health Care!

Enclosed you will find paperwork we need you to complete and bring with you for your appointment. If this is not completed when you come in it may delay your appointment time. Please arrive 20 minutes prior to your appointment time as additional paperwork will be needed at check in as part of the new patient registration process.

§ If your insurance is a managed care plan, a referral is required from your primary care physician in order to be seen by a specialist. With a managed care plan, please call to make sure the referral has been requested from your primary physician and received by the specialist.

§ As a courtesy, our office will contact your insurance company to verify coverage and benefits. Please call us if you have questions about the amount you will need to be prepared to pay at your first appointment. Co-payments, Co-insurance and Deductible amounts are payable at the time of service. We accept cash, checks made payable to Oak Street Medical, Visa, MasterCard and Discover.

§ **If you are being seen for Diabetes**, please be sure to bring your meters and daily logs with you to your appointments.

§ **Late Appointments:** The office may need to reschedule your appointment if you are late or if you do not arrive 20 minutes prior to your appointment time with this completed packet to allow the needed to time to complete new patient registration.

Appointment Policy

Our office requires 24 hour notice if an appointment cannot be kept. If you are unable to make your scheduled appointment, please notify us as soon as possible. You can call our main office number between 8am and 5pm. If before 8am or after 5pm, please leave a message on our voice mail. All "No Show" appointments are tracked within the patient's medical record. There is a $50.00 fee attached to all "No Show" appointments subsequent to the first offense. With any additional "No Show" appointments following the second notice, our office will be unable to schedule any appointments in advance. Patients may call our office on the day he/she is available to attend an appointment to inquire if there is an opening that would work for them. Continued missed appointments will subject the patient's account for review of possible termination from the Practice.

If you have any questions, please feel free to call the office during regular business hours.
We look forward to meeting you soon.

Warmest regards,
The Office Staff
Eugene Endocrinology

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GENERAL INFORMATION

Name: _____ Language(s) spoken: _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____/ _____/_____ Age:_____ Email: _____

REFERRING PROVIDER

Name: _____ Phone Number: _____

REASON FOR VISIT

☐ Adrenal issues	☐ Diabetes Type 1	☐ Diabetes Type 2
☐ Diabetes in Pregnancy	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Osteoporosis	☐ PCOS	☐ Prediabetes / Diabetes prevention
☐ Osteopenia	☐ Pituitary	☐ Parathyroid
☐ Thyroid Cancer	☐ Hypogonadism	☐ Other:_____

ALLERGIES: ☐ No Known Allergies

MEDICATION	REACTION

SURGICAL HISTORY Please list surgeries you've had, date, and hospital ☐ None

SURGERY	DATE	LOCATION

EXAMS YOU'VE HAD DONE:

Eye Exam	Date:	☐	Never
Bone Density	Date:	☐	Never
A1c	Date:	☐	Never

Have you had any hospitalizations, operations, or health events? _____

_____

Please list your primary health concerns:_____

_____

_____

MEDICATION RECONCILIATION: (Please **bring all** your medications/supplements when you come in)		
Name:	Strength:	Frequency:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Pharmacies that you use:_____

OTHER MEDICAL PROVIDERS (Current specialists involved in your care)	
Specialty/Reason Name	**If new patient list medical problems**
Ophthalmologist	
Cardiologist	
Pulmonologist	
Gastroenterologist	
Oncologist	
Dermatologist	
Orthopedist	
Urologist	
Gynecologist	
Allergist	
Dental	
Nephrologist	
Psychologist/Psychiatrist	
Other	

MEDICAL HISTORY Check if now have or have ever had these conditions

CARDIAC

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Irregular heart beat
- ☐ Mitral valve prolapse
- ☐ Peripheral vascular disease
- ☐ Stroke

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Emphysema

MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Other: _____

GASTROINTESTINAL

- ☐ Ulcers
- ☐ Irritable Bowel Syndrome
- ☐ Constipation
- ☐ Diverticulitis
- ☐ Crohns / Colitis

GENITOURINARY/ REPRODUCTIVE

- ☐ Many urine infections
- ☐ Kidney Stones
- ☐ Infertility
- ☐ Erectile Dysfunction

Females:

- ☐ Gestational Diabetes
- ☐ Irregular periods
- ☐ Hysterectomy

Date of last period:_____

PAP:_____

Mammogram:_____

Pregnancies:_____ Births:_____

Miscarriages:_____

HEMATOLOGIC

- ☐ Easy bleeding / bruising
- ☐ History of blood clot

NEUROLOGIC

- ☐ Spine / back injury
- ☐ Seizures
- ☐ Migraines
- ☐ Recurrent headaches

CANCER

- ☐ Type:_____

ENDOCRINE

- ☐ Diabetes
- ☐ Thyroid
- ☐ Osteoporosis
- ☐ High Cholesterol
- ☐ Steroid use
- ☐ Excessive weight gain

Females:

- ☐ Polycystic Ovary Syndrome
- ☐ Unwanted facial or Body hair

FAMILY HISTORY - are you adopted? ☐ Yes ☐ No

Have any of your family members ever had any of the following? (Please cross out any family listed below that doesn't apply to you…e.g. If you don't have a brother, just cross out Brother.)

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Arthritis-Rheum								
Arthritis-Osteoporosis								
Asthma								
Cancer								
Diabetes								
Heart Failure								
High Cholesterol								
Hypertension								
Migraines								
Rashes/Skin Problems								
Seizures								
Stroke								
Thyroid Disease								

REVIEW OF SYSTEMS - please check if you are currently experiencing any of the following

GENERAL WELL-BEING:		**BREAST:**		**EARS, NOSE, THROAT, MOUTH:**	
☐	Weight Loss	☐	Pain	☐	Ulcers
☐	Weight Gain	☐	Gynecomastia	☐	Hoarseness
☐	Fever	☐	Nipple Discharge	☐	Sinus Problems
☐	Fatigue	☐	Breast Lump	☐	Hearing Problems
☐	Excessive Thirst	☐	Rash	☐	Ringing in the Ears
☐	Excessive Hunger			☐	Difficulty Swallowing
☐	Problems Sleeping	**CARDIOVASCULAR:**			
☐	Heat Intolerance	☐	Shortness of Breath	**EYES:**	
☐	Cold Intolerance	☐	Chest Pain	☐	Vision Changes
		☐	Palpitations	☐	Contacts / Glasses
BLOOD SYSTEM:		☐	Swelling	☐	Excessive Tearing / Eye Discharge
☐	Bleed Easily				
☐	Bruise Easily	**RESPIRATORY:**		**MUSCULOSKELETAL:**	
☐	Enlarged Lymph Nodes	☐	Coughing	☐	Weakness
		☐	Coughing up Blood	☐	Muscles Pain
GASTROINTESTINAL:		☐	Wheezing	☐	Joint Pain
☐	Excessive Bloating / Gas				
☐	Diarrhea	**NEUROLOGICAL:**		**URINARY / GYNECOLOGIC:**	
☐	Constipation	☐	Dizziness	☐	Blood in Urine
☐	Nausea / Vomiting	☐	Headache	☐	Painful Urination
☐	Bloody Stools	☐	Near passing out	☐	Urgency or Frequency
☐	Pain with Bowel Movement	☐	Numbness	☐	Pain with Intercourse
☐	Abdominal Pain	☐	Difficulty Walking	Women: ☐	Irregular Periods
		☐	Memory Problems	☐	Vaginal Discharge
PSYCHOLOGICAL:					
☐	Severe Agitation	**SLEEP DISTURBANCE:**		**SKIN:**	
☐	Depression	☐	Difficulty Falling Asleep	☐	Acne
☐	Severe Mood Swings	☐	Waking up Frequently at night	☐	Hair Loss
☐	Anxiety	☐	Excessive Sleepiness during	☐	Hair Growth
☐	Confusion		the day	☐	Dryness
				☐	Rash

SOCIAL HISTORY:

Are you currently married or with a partner?	☐	Yes	☐	No		
Do you smoke?	☐	Yes	☐	No	☐	Never
If yes: How many packs a day?_____	For how long? _____					
If quit: When did you quit? _____						
When you did smoke, how many packs per day? _____ For how long?_____						
Do you exercise?	☐	Yes	☐	No		
If yes: Aerobic activity?	☐	Yes	☐	No	Times per week?_____	
Strength training?	☐	Yes	☐	No	Times per week?_____	
Yoga / Stretching?	☐	Yes	☐	No	Times per week?_____	
Do you drink alcohol?	☐	Yes	☐	No	_____ drinks per day	
Do you consume caffeine?	☐	Yes	☐	No	_____ drinks per day	
Do you currently use recreational drugs?	☐	Yes	☐	No		
Have you used recreational drugs in the past?	☐	Yes	☐	No		

PEDIATRIC PATIENTS :

Birth History	Pregnancy Complications_____
	Gestational age at birth _____ weeks
	Birth Weight _____lbs Birth Length _____inches

Developmental Milestones:	Sat up unsupported- _____ months
	Walked _____ months
Were there any growth concerns? _____	
Any other concerns? _____	

Girls:	Age of breast buds? _____ years	Boys:	Age of puberty onset? _____ years
	Age of first period? _____ years		Age of growth spurt? _____ years
	Last menstrual period? _____		