MEMORIAL ENDOCRINOLOGY AND DIABETES

Medication List

Name: ______________________________ **DOB:** __________________

DRUG	STRENGHT	DIRECTION

Memorial Endocrinology And Diabetes
1140 BUSINESS CENTER DR, SUITE 550, HOUSTON, TEXAS 77043
PHONE: 713-984-8200 FAX: 713-984-1113

Donald F. Gardner, MD, FACP **Foiqa A. Chaudhry, MD, ECNU** **Blessy A. Varughese, DO, MPH**

HEALTH QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: _____ ☐ M ☐ F **Today's Date:** _____

Address: _____
Street City State Zip

Age: _____ **Date of Birth:** _____ **Marital status:** ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Occupation: _____ **Employer:** _____

Referred By: _____

Briefly describe in your own words the problems which caused you to consult a physician today:

FAMILY HISTORY

RELATIVE	AGE	DECEASED Yes	DECEASED No	ILLNESSES	PHYSICIAN'S COMMENTS
Father	_____	☐	☐		
Mother	_____	☐	☐		
Brother/Sister	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
Children	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		
	☐ M ☐ F ___	☐	☐		

Have any of your relatives (parents, brothers, sisters or children) had any of the following?

	Yes	No
Heart attack	☐	☐
Stroke	☐	☐
High blood pressure	☐	☐
Diabetes	☐	☐
High cholesterol	☐	☐
Thyroid trouble	☐	☐
Tuberculosis	☐	☐
Cancer	☐	☐
High Calcium	☐	☐
Abdominal aortic aneurysm	☐	☐

MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Drug Name	Dose	Times per day

Allergies to medications

Drug Name	Side effects or Reactions

Other Allergies

Have you ever had a very severe or life threatening reaction to any substance? ☐ ☐

If yes, please explain:

HABITS

Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per week?		
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe		
	☐ # of years ☐ Or year quit		
Drugs	Do you currently use recreational drugs?	☐ Yes	☐ No

HOSPITALIZATIONS

Date **Reason**

Other hospitalizations

Date **Illness / Operation**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

General and Endocrine

	Yes	No
Fatigue	☐	☐
Fever	☐	☐
Weight gain or loss	☐	☐
(more than 5 lbs in last year)	☐	☐
Diabetes	☐	☐
Elevated cholesterol	☐	☐
Excessive thirst or urination	☐	☐
Problems with warm or cold temperatures	☐	☐
Excessive snoring or sleepiness	☐	☐
Bleeding disorder or coagulation problems	☐	☐
Weakness	☐	☐

Head and Neck

	Yes	No
Fainting or blackouts	☐	☐
Difficulty with vision	☐	☐
Glaucoma	☐	☐
Frequent or severe headaches	☐	☐
Stroke or paralysis	☐	☐
Seizures or epilepsy	☐	☐
Difficulty swallowing	☐	☐
Persistent hoarseness	☐	☐
Thyroid trouble or enlarged thyroid (goiter)	☐	☐
Head or neck pain	☐	☐

Chest and Circulatory

	Yes	No
Persistent cough	☐	☐
Shortness of breath	☐	☐
Wheezing or asthma	☐	☐
Coughing up blood	☐	☐
High blood pressure	☐	☐
Chest pain	☐	☐
Heart attack	☐	☐
Heart murmur or other heart trouble	☐	☐
Heart palpitations or racing	☐	☐
Swelling or collection of fluid in the legs and ankles	☐	☐
Tuberculosis or positive TB Skin Test	☐	☐
Abnormal chest x-ray	☐	☐
Phlebitis or blood clots	☐	☐
Pain in the legs when walking	☐	☐

Abdomen

	Yes	No
Indigestion or heartburn	☐	☐
Recent abdominal pain	☐	☐
Stomach or duodenal ulcer	☐	☐
Problems with constipation	☐	☐
Recurrent or severe diarrhea	☐	☐
Recent nausea or vomiting	☐	☐
Gallstones	☐	☐
Yellow jaundice or hepatitis	☐	☐
Blood in stools	☐	☐

Kidney and Bladder

	Yes	No
Burning on urination	☐	☐
Waking at night to urinate	☐	☐
Kidney stones	☐	☐
Blood in the urine	☐	☐
Difficulty starting your urine or poor stream	☐	☐
Kidney disease or nephritis	☐	☐
History of bladder or kidney infection	☐	☐

Musculoskeletal

	Yes	No
Fractures or broken bones If yes, please list:	☐	☐
Osteoporosis	☐	☐
Recurrent or severe low back pain or strain	☐	☐
History of arthritis (pain, swelling, or stiffness of joints)	☐	☐
Frequent muscle cramps	☐	☐
Bone or muscle pain	☐	☐

Women Only

	Yes	No
Discharge from breasts	☐	☐
Other breast problems	☐	☐
Irregular menstrual periods	☐	☐
Abnormal periods in any way (heavy flow, severe cramps, spotting)	☐	☐
Problems with sexual function	☐	☐
Excessive hair growth	☐	☐

Men Only

	Yes	No
Problems with sexual function or intercourse	☐	☐
Prostate problems	☐	☐
Difficulty having or maintaining erections	☐	☐
Enlargement of the breasts	☐	☐

Emotional

	Yes	No
Problems with nervousness, anxiety or tension	☐	☐
Feelings of depression	☐	☐
Difficulty sleeping	☐	☐
Received care from a psychiatrist	☐	☐
Seriously considered suicide	☐	☐

FOR DIABETIC PATIENTS – PLEASE CONTINUE TO NEXT PAGE

FOR DIABETIC PATIENTS ONLY

Age at diagnosis of diabetes? _____

Weight at the time of diagnosis? _____

Have you ever been treated for ketoacidosis? Yes ☐ No ☐

If yes, how many times? _____

Date of last episode? _____

Do you test your own blood sugar? Yes ☐ No ☐

How often do you test your blood sugar?

_____

_____

What do your blood sugar tests usually show?

Before breakfast _____

Before lunch _____

Before supper _____

Before bedtime _____

	Yes	**No**
Do you have or have you had:		
Protein in the urine?	☐	☐
Kidney disease from diabetes?	☐	☐
Eye disease from diabetes (retinopathy)?	☐	☐
Laser treatments for your eyes?	☐	☐
Ulcers of the feet or skin?	☐	☐
Are you taking an oral hypoglycemic tablet (a pill for diabetes)?	☐	☐
Have you ever had low blood sugar reactions from the diabetes tablet?	☐	☐
Numbness, burning or tingling of the hands or feet?	☐	☐
Frequent urination?	☐	☐
Excessive thirst?	☐	☐
Yeast (fungus) infections of the skin?	☐	☐
Weight change in the last year?	☐	☐
If yes, how much have you gained or lost?	Gained _____	
	Lost _____	

Describe your diet:

Number of snacks _____

Do you use carbohydrate counting? Yes ☐ No ☐

What was the date of your last appointment with your ophthalmologist (physician who specializes in treatment of eye diseases)? _____

Date Physician Name

FOR DIABETIC PATIENTS WHO USE INSULIN

Do you use insulin injections? Yes ☐ No ☐

Type of insulin	Units	Times
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have insulin reactions? Yes ☐ No ☐

How often do your reactions occur?
_____ per day
_____ per week
_____ Per month

At what time or times per day do your reactions occur?
If there is no pattern, write "no pattern":
_____
_____
_____

Have you ever had loss of consciousness with an insulin reaction? Yes ☐ No ☐

Have you ever had an epileptic seizure (a convulsion) due to a severe insulin reaction? Yes ☐ No ☐

Are you currently using an insulin pump? Yes ☐ No ☐

Pharmacy Information

We now have the ability to send prescriptions to your pharmacy electronically. Please fill out the following information so that we may add it to your data base.

Patient name: _____

Local pharmacy: _____

Local pharmacy address: _____

_____

Local pharmacy telephone no.:_____

Mail in prescription service (if used):_____

Mail in prescription service address: _____

_____

Mail in prescription service telephone no.:_____

Patient Privacy

Name:_____DATE:_____

DO WE HAVE PERMISSION TO?

Leave a message on your answering machine at home? **Yes or No**

Leave test results or appointment confirmations on your answering machine at home? **Yes or No**

Leave a message at your place of employment? **Yes or No**

Leave a message on your cell phone voice mail? **Yes or No**

Leave test results or appointment confirmations on your cell phone voice mail? **Yes or No**

Send appointment reminder cards/missed appointment cards to you by mail? **Yes or No**

Fax copies of your results to another physician if necessary? **Yes or No**

If offered in the future would you like appointment reminders through email? **Yes or No**

E-MAIL ADDRESS_____

Initial here_____

I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be use and disclosed. I understand that I am entitled to receive a copy of this document. Initial here_____

Please list any persons in which we have you permission to discuss your medical condition or test results:

_____ _____

_____ _____

Insured Patients
I authorized the release of any medical or other information necessary to process my insurance claims. I certify that the information I furnish is true and correct. _____ Initial here

I authorize payment of medical benefits to MEMORIAL CITY ENDOCRINE CONSULTANTS. I understand that I maybe responsible for any amount not paid by my insurance company if they are deemed non-covered items.
_____ Initial here

Self Paid (non insured) Patients
I certify that I do not have insurance benefits and that I will not be filing to an insurance company for reimbursement of these charges.
_____ Initial here

Signature of Patient or Personal Representative

Name of Personal Representative (If applicable)

Relationship to patient

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

· Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
· Obtain payment from third-party payers.
· Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice *of* Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice *of* Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice *of* Private practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature:_____

Date:_____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

Cancellation /No Show Policy

For Doctor Appointments and Procedures

At ***Memorial Endocrinology & Diabetes***, we put our faith in you to keep your appointment and be on time. When we schedule an appointment, a specific amount of time is reserved especially for you!

Cancellations (in-office and/or telehealth):

Because appointments are in high demand, if for any reason you must cancel or change your appointment, it is important that you give our office at least 48 hours' notice to offer that spot to someone else. *In failing to do so, you will be charged a $35.00 fee to be paid before further services are rendered.*

Cancelled Biopsy Appointments:

Please arrive 45 minutes before your appointment to complete consent form and allows time for the anesthetic cream to work. Notify the office if you are taking a prescription blood-thinner other than Aspirin.

We require a 48 hours' notice if you cannot keep your appointment for a procedure. *By failing to keep your appointment for a Biopsy without notification, you will be charged a $50.00 fee to be paid before further services are rendered.*

If you're late:

If you arrive more than 15 minutes late for your appointment time, you may be asked to reschedule in order to meet the needs of those who are on time. Priority will be given to the patients who arrive on time. One or two late patients can cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.

If we're late:

Sometimes a patient comes in that requires additional attention. This can cause the doctor to run late for the rest of the day. We will do our very best to notify you when this happens. We hope we can make you as comfortable as possible while you wait. If you would like to go down to the cafeteria and get a cup of coffee we can call you on your cell phone when the doctor is ready. You may also prepare for the wait by bringing a book to read or something you enjoy doing before your appointment.

Free Wi-Fi is available.

_____	_____	____/___/___
Patient/Guardian Name- Print	**Patient/Guardian Signature**	**Date**