The Endocrine Center Houston
10837 Katy Freeway, Suite 200 | Houston, TX 77079
Phone: 713-468-2122
Fax: 713-468-2289

Last Name _____ **First Name** _____ **MI** _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Preferred Contact Phone Number **HOME #** _____ **CELL #** _____

Email address: _____ **Birth Date** _____

Sex _____ **Social Security** _____ **Driver Lic. #** _____

Marital Status: (select one) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow** **Student Status:** ☐ **Full Time** ☐ **Part-time** ☐ **Non-student**

Preferred Language: _____ **Ethnicity:** (select one) ☐ **HISPANIC** **or** ☐ **NON-HISPANIC**

Race: (select one): **American Indian / Alaskan Native;** ☐ **Asian;** ☐ **African American;** ☐ **Caucasian;** ☐ **Pacific Islander;** ☐ **Other;** ☐ **Declined** ☐

Primary Insurance: _____ **ID #:** _____

Secondary Insurance: _____ **ID #:** _____

Employer: _____

Street _____ **City** _____ **State** _____ **Zip Code** _____

Work Telephone # _____ **Ext: #** _____ **Fax #** _____

Referring Physician: _____ **Phone #** _____

Relationship to Insured: (select one) ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

If not self please provide the information for responsible party.

Name: _____

Street: _____ **City** _____ **State** _____ **Zip Code** _____

Phone #: _____ **Work #:** _____ **Social Security #:** _____ **Date of Birth:** _____

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Emergency Contact

Name: _____ **Relationship** _____ **Phone #** _____

Name: _____ **Relationship** _____ **Phone #** _____

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Acknowledgement of Review of Privacy Practice

I have reviewed this office's Notice of Privacy Practices and HIPPA regulations, which explained how my medical information will be issued and disclosed.
I understand that I am entitled to receive a copy of this document.

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I hereby assign, transfer and set over to The Endocrine Center, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization I understand that I am financially responsible for all charges weather or not they are covered by insurance. I authorized
The Endocrine Center to treat as necessary for which I or my minor child is being seen. This includes, but is not necessarily limited to, injections, labs, diagnostic testing or any other treatment deemed proper care of my illness.

_____ _____

Signature of Patient / Guardian / Representative **Date**

The Endocrine Center Medical History

Patient Name: _____ **Date:** _____

Current medical problems -- Please list the medical problems for which you came to see the doctor:

Referring physician _____ Phone number _____

Primary Care physician _____ Phone number _____

Name of pharmacy _____ Phone number _____

Please provide a **list of medications** you are now taking; include **frequency and dosage**. Include those you buy without a doctor's prescription such as aspirin, cold tablets, vitamin supplements, etc.

Current allergies, sensitivities, and intolerances. List anything to which you are allergic such as foods, medications, dust, chemicals, bee stings, etc.

Other Medical Care:
Please describe any other illnesses or medical problems you are being treated for; include the name of the physician or mental health practitioner as well as the name of the facility

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Past Medical History

Diabetes: Type_____	Yes	No
High Cholesterol	Yes	No
Hypertension (high blood pressure)	Yes	No
Diabetic Foot Exam Date_____	Yes	No
Retinal Exam Date_____	Yes	No
Hypothyroid (underactive thyroid)	Yes	No
Hyperthyroid (overactive thyroid)	Yes	No
Thyroid Nodule	Yes	No
Thyroid Cancer	Yes	No
Coronary Artery Disease / Heart Blockage	Yes	No
Congestive Heart Failure	Yes	No
Osteoporosis / Osteopenia	Yes	No
Prostate Cancer	Yes	No
Breast Cancer	Yes	No
Date of last mammogram_____	Yes	No
Date of last PAP Smear _____	Yes	No
Blood Clots / DVT	Yes	No
Other Cancer Type _____		
Pituitary Problem / Disease	Yes	No
Kidney Stones	Yes	No
Kidney Disease	Yes	No
Chronic Renal Insufficiency	Yes	No
CVA / Stroke	Yes	No
Peptic Ulcer / GERD	Yes	No
Colonoscopy Date_____	Yes	No
Asthma / COPD	Yes	No
Depression	Yes	No
Anxiety	Yes	No

Other Medical History

Social History

Never smoker	Yes	No
Current every day smoker	Yes	No
Current some day smoker	Yes	No
Former smoker	Yes	No
Alcohol use Quantity_____	Yes	No
Past drug use	Yes	No
Current drug user	Yes	No

Exercise_____

Occupation _____

With whom do you live

Family History

Diabetes	Yes	No

If Yes, Relation: _____

Hyperthyroidism	Yes	No
Thyroid Cancer Type_____	Yes	No
Heart Disease (CAD)	Yes	No
Hypertension (high blood pressure)	Yes	No
High Cholesterol	Yes	No
Osteoporosis / Osteopenia	Yes	No
Stroke	Yes	No
Breast Cancer	Yes	No
Prostate Cancer	Yes	No

If Yes, Relation: _____

Other Cancers: Type_____

Other Family History:

Surgical History

	Date		
Cataract (eye) surgery		Yes	No
Tonsillectomy (tonsils removed)		Yes	No
Thyroidectomy (thyroid surgery)		Yes	No
Thyroid Biopsy		Yes	No
Breast Biopsy		Yes	No
Mastectomy / Lumpectomy		Yes	No
Coronary Artery Bypass (heart surgery)		Yes	No
PTCA Angioplasty / Stent		Yes	No
Aortic or Mitral Heart Valve Repair		Yes	No
Pacemaker		Yes	No
Appendectomy (appendix removed)		Yes	No
Cholecystectomy (gallbladder removed)		Yes	No
Hysterectomy (total/partial)		Yes	No
Caesarian Section		Yes	No
Tubal Ligation ("tubes tied")		Yes	No
Urinary or bladder surgery		Yes	No
Prostate Surgery		Yes	No
Hernia Repair		Yes	No
Colectomy (colon removal)		Yes	No
Back surgery		Yes	No
Hip surgery		Yes	No
Knee surgery		Yes	No

Other Surgical History

The Endocrine Center Authorization To Release Medical Records

Dr. Amer Al-Karadsheh, MD
Dr. Daniel Tung, MD
Dr. Saritha Mittadodla, MD

Dr. Christina Michaelis, MD
Dr. Prashant Koshy, MD
Dr. Samir Ouais, MD

Dr. Maria Lee, MD
Dr. Qureshi, MD
Dr. Nwachukwu, MD

10837 Katy Freeway Suite 200 Houston, TX 77079
Phone 713.468.2122 *Fax 713.468.2289*
www.endocrinecenterhouston.com

Patient Name: _____

Date of Birth: _____ **Date:** _____

Doctor : _____

This letter will serve as authorization for you to provide a copy, summary or narrative of my medical record. Include any information regarding psychiatric history, HIV status and / or drug testing. As identified by the check mark below.

☐ Complete record

☐ Treatment records from _____ to _____

☐ The first and last five patient encounters – progress notes only

☐ All lab and X-Ray reports for _____

☐ All lab and X-Ray reports

I am requesting the release of records due to _____

_____

Patient signature

3 Ways To Submit This Form:

1) Save the form as a PDF. Print the form and Fax to: 713-468-2289 or bring with you to your next appointment.

2) Save the form as a PDF. Email it to us at info@endocrinecenterhouston.com

3) If you have Outlook or another mail program already setup to send mail from your computer or device, you can submit the form automatically by clicking the SUBMIT FORM button:

SUBMIT FORM