PATIENT DEMOGRAPHIC INFORMATION:

Last Name:_____ Date of Birth:_____

First Name:_____ Sex: ◯ Male ◯ Female

Social Security Number:_____

Marital Status: ◯ Married ◯ Single ◯ Divorced/Separated ◯ Domestic Partner

Cell phone:_____ Home phone:_____

Email:_____

Address:_____

City:_____ State:_____ Zip Code:_____

PATIENT INSURANCE INFORMATION:

Primary Insurance Company:_____

Plan Name:_____ Phone Number:_____

Name of Insured:_____ Relationship:_____

Member ID #:_____ Group #:_____

Secondary Insurance Company:_____

Plan Name:_____ Phone Number:_____

Name of Insured:_____ Relationship:_____

Member ID #:_____ Group #:_____

Guarantor Information (if different from patient):

Name:_____ Social Security Number:_____

Date of Birth:_____ Cell Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Email:_____

PHARMACY INFORMATION:

Retail Pharmacy:_____

Pharmacy phone number:_____

Pharmacy address:_____

Mail Order Pharmacy:_____

Pharmacy phone number:_____

Pharmacy address:_____

Do you consent to the retrieval of your prescription filling history? ◯ Yes ◯ No

Primary Medical Doctor:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Emergency Contact Information:

Name:_____ Phone:_____

Health Care Proxy (If different from Emergency Contact):

Name:_____ Phone:_____

PATIENT GENERAL MEDICAL HISTORY:

Reason for visit:

Have you ever suffered from or been diagnosed from the following conditions?

- ☐ Stroke
- ☐ Seizure
- ☐ Migraines
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Congestive Heart Failure
- ☐ Cardiac Arrythmias
- ☐ Coronary Disease
- ☐ Other heart disease (Please specify)
- ☐ Asthma
- ☐ COPD
- ☐ Cancer (Specify type)
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Celiac disease
- ☐ Kidney Disease (Specify type)
- ☐ Broken Bones or Fractures
- ☐ Arthritis
- ☐ Other

Please list dates and types of any surgeries:

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____

PATIENT ENDOCRINE HISTORY:

Have you ever been diagnosed with:

- ☐ Pituitary disorders or tumors
- ☐ Thyroid disorders
- ☐ Thyroid nodules
- ☐ Diabetes (specify type)
- ☐ Adrenal Insufficiency
- ☐ Cushing's syndrome
- ☐ Other adrenal disorder (specify type)
- ☐ Osteoporosis
- ☐ Parathyroid disorder
- ☐ Infertility
- ☐ Irregular Menses
- ☐ Erectile Dysfunction

Have any members of your family been diagnosed with:

- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Autoimmune Disorder (specify)
- ☐ Other endocrine disorder (specify)

PATIENT SOCIAL HISTORY:

Do you currently or have you ever smoked cigarettes? ◯ NO ◯ YES ◯ QUIT (DATE)

How often do you drink alcoholic beverages?

Do you use any recreational or street drugs (eg marjiuana)?

PATIENT MEDICATION HISTORY:

Please list all prescription medications and supplements/vitamins you currently use:
Include the dose and frequency

Do you have any allergies to food, medications, or other substances? ◯ No known allergies ◯ Yes, see list

If yes, please list: