FRONTIER MEDICAL & BEHAVIORAL CENTER
www.frontiermbc.com

Primary / Endocrinology New Patient History Form

Patient Name: _____ DOB:_____ Age: _____

How did you hear about us? [ ] Patient [ ] Family Member [ ] Physician _____ [ ] Other: _____

Main Reason for Today's Visit? _____

_____

List other Providers and Specialties:

[ ] Primary Care _____ [ ] Pulmonologist _____ [ ] Rheumatologist _____

[ ] Cardiologist _____ [ ] Oncologist _____ [ ] Nephrologist _____

[ ] Gastroenterologist _____ [ ] OB/GYN _____ Others: _____

Allergies: _____ [ ] No known Drug Allergies

Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? [ ] Y [ ] N

Medical History:

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

RESPIRATORY
- ❑ Asthma
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Emphysema

GASTROINTESTINAL
- ❑ Ulcers
- ❑ Irritable bowel
- ❑ Constipation
- ❑ Diverticulitis
- ❑ Colitis

GENITOURINARY/ REPRODUCTIVE
- ❑ Many urine infections
- ❑ Kidney stones
- ❑ Infertility

Males: ❑ Erectile Dysfunction

Females: ❑ Gestational diabetes
❑ Irregular periods

MUSCULOSKELETAL
- ❑ Arthritis
- ❑ Other_____

HEMATOLOGIC
- ❑ Easy bleeding / bruising
- ❑ Hx of blood clot

CANCER
- ❑ Type: _____

ENDOCRINE
- ❑ Diabetes
- ❑ Thyroid
- ❑ Osteoporosis
- ❑ High cholesterol
- ❑ Steroid use
- ❑ Excessive weight gain
- ❑ Polycystic Ovary Syndrome

NEUROLOGIC
- ❑ Spine / back injury
- ❑ Seizures
- ❑ Migraines
- ❑ Recurrent headaches

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Patient Name: _____ DOB: _____

List all current prescribed and over the counter **MEDICATIONS**:

Medication	Dose	Frequency

Health Maintenance Screening Tests

Cholesterol	Date:	Provider:	Abnormal [ ] Y [ ] N
Colonoscopy / Sigmoid	Date:	Provider:	Abnormal [ ] Y [ ] N
Mammogram	Date:	Provider:	Abnormal [ ] Y [ ] N
Pap - Smear	Date:	Provider:	Abnormal [ ] Y [ ] N
Bone Density	Date:	Provider:	Abnormal [ ] Y [ ] N

Vaccination History

Last Tetanus Booster or Tdap:	Last Pneumovax (Pneumonia):
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine:	

Surgeries [ ] No Surgeries

Type	Date	Location

Women's Health History

Date of Last Menstrual Cycle: _____ Age of 1st Menstruation: _____
Total Number of Pregnancies: _____ Age of Menopause: _____
Pregnancy Complications: _____ Number of Live Births: _____

Social History

Occupation (or prior) : _____ [ ] Retired [ ] Unemployed [ ] Disabled
Employer: _____ Highest Degree: _____
If Employed, do you work night shift? [ ] Y [ ] N
Marital Status: [ ] Single [ ] Partner [ ] Married [ ] Divorced [ ] Widowed [ ] Other: _____
Children: [ ] Y [ ] N If Yes, How Many? _____

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Family Medical History

Check all that apply

	Heart Disease	Asthma	High Cholesterol	High Blood Pressure	Cancer Type:	Early Death	Stroke	Thyroid Disease	Bipolar Suicidal	Depression	Migraines	Others:
Mother												
Father												
Brother/s												
Sister/s												
MGM												
MGF												
PGM												
PGM												
Child												

Other Health Issues

Tobacco Use: Smoke Cigarettes [ ] Y Current: Packs/Day _____ # of years _____
[ ] N Past: Quit Date: _____ Packs/Day _____ # of years _____
Other Tobacco: [ ] Pipe [ ] Cigar [ ] Chew [ ] Snuff

Alcohol/Drug Use:
Do you drink Alcohol? [ ] Y [ ] N - [ ] Beer [ ] Wine [ ] Liquor # Drinks / Week _____
Do you use Marijuana or Recreational Drugs? [ ] Y [ ] N
Have you ever used needles to inject drugs? [ ] Y [ ] N

Sexual Activity:
Sexually Involved? [ ] Y [ ] N Sexual Partners is/are/have been: [ ] Male [ ] Female
Birth Control Method: [ ] None [ ] Condom [ ] Pill/Ring/Patch/IUD [ ] Vasectomy

Exercise: Do you exercise regularly? [ ] Y [ ] N If so, what kind of exercise? _____
How many times a week? _____ and how long (min) _____

Sleep: How many average hours of sleep? _____

Diet: How would you rate your diet. [ ] Good [ ] Fair [ ] Poor
Would you like advice on your diet? [ ] Y [ ] N

Safety: Do you use a bike helmet? [ ] Y [ ] N
Do you use seatbelt consistently? [ ] Y [ ] N
Working smoke detector in home? [ ] Y [ ] N
If you have guns at home, are they locked up? [ ] Y [ ] N
Is violence at home a concern for you? [ ] Y [ ] N

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Patient Name: _____ DOB: _____

Review of Systems (check all that apply)

GENERAL WELL-BEING:
❑ Weight Loss
❑ Weight Gain
❑ Fever
❑ Fatigue
❑ Excessive Thirst
❑ Excessive Hunger
❑ Problems Sleeping
❑ Heat Intolerance
❑ Cold Intolerance

BLOOD SYSTEM:
❑ Bleed Easily
❑ Bruise Easily
❑ Enlarged Lymph Nodes

GASTROINTESTIONAL:
❑ Diarrhea
❑ Constipation
❑ Nausea / Vomiting
❑ Bloody Stools
❑ Pain with bowel movement
❑ Excessive bloating / Gas

SLEEP DISTURBANCE:
❑ Difficulty Falling Asleep
❑ Waking up frequently at night
❑ Excessive Sleepiness during day

BREAST:
❑ Pain
❑ Nipple Discharge
❑ Breast Lump
❑ Rash

CARDIOVASCULAR:
❑ Shortness of Breath
❑ Chest Pain
❑ Palpitations
❑ Swelling

RESPIRATORY:
❑ Coughing
❑ Coughing up Blood
❑ Wheezing

PSYCHOLOGICAL:
❑ Depression
❑ Severe Mood Swings
❑ Anxiety
❑ Confusion
❑ Severe Agitation

SKIN:
❑ Acne ❑ Hair Loss
❑ Hair Growth ❑ Dryness
❑ Rash

EARS, NOSE, THROAT, MOUTH:
❑ Ulcers
❑ Sinus Problems
❑ Hearing Problems
❑ Ringing in the Ears
❑ Difficulty Swallowing

EYES:
❑ Vision Changes
❑ Contacts / Glasses
❑ Excessive Tearing / Eye Discharge

MUSCULOSKELETAL:
❑ Weakness
❑ Muscle Pain

NEUROLOGICAL:
❑ Dizziness ❑ Headache
❑ Near passing out ❑ Numbness
❑ Difficulty Walking ❑ Memory Problems

URINARY / GYNECOLOGIC:
❑ Blood in Urine ❑ Painful Urination
❑ Urgency or Frequency
❑ Pain with Intercourse
Women: ❑ Irregular Periods
❑ Vaginal Discharge

Additional Information
Have you traveled out of the country in the past 30 days? [ ] Y [ ] N, If yes, where? _____
Have you served in the military? [ ] Y [ ] N, If yes, how long and what branch? _____
Were you deployed? [ ] Y [ ] N, If yes, where? _____

IF YOU HAVE **DIABETES,** complete the following questions:

At what age was your diabetes diagnosed? _____ Have you seen a diabetes educator? ❑ Yes ❑ No

Have you seen a nutritionist regarding your diabetes? ❑ Yes ❑ No

What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Diabetes in pregnancy ❑ Do not know

Do you check your blood sugars at home? ❑ Yes ❑ No

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If yes, what is a high reading for you? _____ what is a low reading for you? _____

Do your sugars ever go below 70? ❑ Yes ❑ No If yes, is this ❑ daily ❑ weekly ❑ monthly ❑ rarely

Are you aware of when your sugars go low? ❑ Yes ❑ No

Have you been hospitalized for low blood sugars? ❑ Yes ❑ No

If yes, when _____ and where _____

Do you know what an A1c is? ❑ Yes ❑ No

Do you know your A1c? ❑ Yes ❑ No If yes what is it? ____

Have you ever been hospitalized for high blood sugars? ❑ Yes ❑ No

If yes, when _____ and where _____

Do you have diabetes related eye problems? ❑ Yes ❑ No Eye Doctor: _____

When was your last eye exam? _____ ❑ Never

Do you have foot problems? ❑ Yes ❑ No Who is your Foot Doctor: _____

When did you last give a urine sample for your diabetes? _____ ❑ Never

Do you have diabetes related kidney problems? ❑ Yes ❑ No

When did you last have a cardiac assessment? _____ ❑ Never

Do you have heart disease? ❑ Yes ❑ No

Males: Do you have erectile dysfunction? ❑ Yes ❑ No

Do you have any specific issues you would like to address with your physician regarding your diabetes?

_____ _____ _____

Patient/Guardian Printed Name Patient/Guardian Signature Date

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