New Patient Registration Form

West Michigan Endocrine
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Today's date (mm/dd/yyyy)	Primary Care Physician (PCP)

PATIENT INFORMATION

Patient's Legal Last Name:	First:	Middle:	Mr.	Ms.
			Mrs.	Dr.

Former Name:	DOB (mm/dd/yyyy)	Age:	Male ☐	Female ☐	SSN (XXX-XX-XXXX)

Street Address:	P.O. Box:	Home Phone:	Cell Phone:

City:	State (XX)	Zip Code:	Referred By:

Occupation:	Employer:	Employer Phone:

Reason for clinic visit:

INSURANCE INFORMATION

Please give insurance card to the receptionist

Person responsible for bill:	DOB mm/dd/yyyy	Address (if different)	Home Phone (if different)

Occupation:	Employer:	Employer Address:	Employer Phone:

Is this person a patient here?	Yes	☐	No	☐	Is this patient covered by insurance?	Yes	☐	No	☐

Please indicate primary insurance:

Subscriber's name:	DOB mm/dd/yyyy	Group Number:	Policy Number:	Co-Payment:

Patient's relationship to subscriber:	Self	☐	Spouse	☐	Child	☐	Other	☐

Name of secondary insurance (if applicable):	Subscriber's name:	Group No:	Policy Number:

Patient's relationship to subscriber:	Self	☐	Spouse	☐	Child	☐	Other	☐

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone:	Work Phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially resonsible for any balance. I also authorize West Michigan Endocrine or insurance

Patient/Guardian Signature

Date

SOCIAL									
Marital Status	Single	☐	Married	☐	Divorced	☐	Separated	☐	
Occupation	Retired	☐	Active	☐	Type:				

Do you? (Check yes or no and explain if yes)						
Get exercise	No	☐	Yes	☐	Hrs/Week:	Exercise Type:
Use illegal drugs	No	☐	Yes	☐	Frequency:	Type:
Consume alcohol	No	☐	Yes	☐	Ounces per week:	
Use tobacco currently	No	☐	Yes	☐	Packs per day:	
Use tobacco past	No	☐	Yes	☐	Packs per day:	

PAST MEDICAL	
What medications, supplements and vitamins are your currently taking? Please list name, dose and frequency.	
1	7
2	8
3	9
4	10
5	11
6	12

Do you have any allergies/reactions? Please list reactions
1
2

Previous Surgeries/Dates:	
1	Date:
2	Date:
3	Date:
4	Date:

Problems for which you have seen a physician or have been treated for:						
Diabetes	No	☐	Yes	☐	Year:	Type:
Thyroid Disease	No	☐	Yes	☐	Year:	Type:
Nodule/Tumor/Cancer	No	☐	Yes	☐	Year:	Type:
High Cholesterol	No	☐	Yes	☐	Year:	
Stroke	No	☐	Yes	☐	Year:	Type:
High Blood Pressure	No	☐	Yes	☐	Year:	
Heart Problem	No	☐	Yes	☐	Year:	Type:
Eye Disease	No	☐	Yes	☐	Year:	Type:
Kidney Disease	No	☐	Yes	☐	Year:	Type:
Other Medical History						

FAMILY					
Do any of your blood relatives have or have had any of these diseases or do any other problems run in the family?					
Diabetes	No	☐	Yes	☐	Type:
Thyroid Disease	No	☐	Yes	☐	Type:
Nodule/Tumor/Cancer	No	☐	Yes	☐	Type:
Heart Problem	No	☐	Yes	☐	Type:
Pituitary Tumor	No	☐	Yes	☐	
Stroke	No	☐	Yes	☐	
High Blood Pressure	No	☐	Yes	☐	
High Cholesterol	No	☐	Yes	☐	
Other Family History					

REVIEW OF SYSTEMS

Place a check in any box if you have had any of the following symptoms in the last 3 months:

Constitutional Symptoms

Symptom	☐	Symptom	☐
Activity change	☐	Fatigue	☐
Appetite change	☐	Fever	☐
Chills	☐	Weight change	☐
Diaphoresis	☐		

Skin

Symptom	☐	Symptom	☐
Itching	☐	New spots	☐
Color Change	☐	Changed spots	☐
Pallor	☐		

Rash

Symptom	☐	Symptom	☐
Wound	☐	Hair changes	☐
Nail changes	☐		

Cardiovascular

Symptom	☐	Symptom	☐
Chest pain	☐	Orthopnea/Shortness of breath	☐
Palpitations	☐	Claudication/Pain in legs	☐

Ear - Nose - Throat

Symptom	☐	Symptom	☐
Ear discharge	☐	Rhinorrhea/runny nose	☐
Hearing loss	☐	Sneezing	☐
Ear pain	☐	Sore throat	☐
Tinnitus/ringing	☐	Hoarse voice	☐
Nosebleeds	☐	Trouble swallowing	☐
Congestion	☐	Mouth sores	☐

Breast

Symptom	☐	Symptom	☐
Breast lump	☐	Breast pain	☐
Breast discharge	☐	Breast mass	☐
Nipple changes	☐	Breast dimpling	☐
Nipple discharge	☐	Breast changes	☐
Breast redness	☐		
Breast swelling	☐		

Gastrointestinal

Symptom	☐	Symptom	☐
Heartburn	☐	Rectal pain	☐
Nausea	☐	Rectal bleeding	☐
Vomiting	☐	Blood in stool	☐
Abdominal Pain	☐	Bloating	☐
Constipation	☐	Burping	☐
Diarrhea	☐	Cramping	☐
Fecal Incontinence	☐	Gas	☐

Genitourinary/Urinary

Symptom	☐	Symptom	☐
Difficulty urinating	☐	Flank pain	☐
Dysuria	☐	Menstrual problem	☐
Incontinence	☐	Pelvic pain	☐
Frequency	☐	Sexual dysfunction	☐
Frequent urination	☐	Vaginal bleeding/discharge	☐

Eyes

Symptom	☐	Symptom	☐
Eye discharge	☐	Eye redness	☐
Eye itching	☐	Light sensitivity	☐
Eye pain	☐	Visual disturbance	☐

Respiratory

Symptom	☐	Symptom	☐
Cough	☐	Shortness of breath	☐
Choking	☐	Chest tightness	☐
Wheezing	☐	Sputum production/mucus	☐
Snoring	☐		

Musculoskeletal

Symptom	☐	Symptom	☐
Neck pain	☐	Muscle pain	☐
Back pain	☐	Gait problems	☐
Joint pain	☐	Falls	☐
Joint swelling	☐	Edema / Swelling	☐

Neurological

Symptom	☐	Symptom	☐
Headaches	☐	Seizures	☐
Dizziness	☐	Tremors	☐
Light headedness	☐	Numbness / tingling	☐
Speech difficulty	☐	Weakness	☐
Loss of conciousness	☐		

Psychiatric

Symptom	☐	Symptom	☐	Symptom	☐
Depression	☐	Hallucinations	☐	Hyperactive	☐
Suicidal ideas	☐	Self injury	☐	Behavior problems	☐
Anxiety	☐	Sleep disturbance	☐	Decrease concentration	☐

Endocrine

Symptom	☐
Adenopathy	☐
Bruises Easily	☐

Please fill out the following section that pertains to your reason for receiving care at West Michigan Endocrine. (For example, if you are seeking care for Thyroid Disease, fill out only that section and leave the others blank.) If more than one section pertains to your care, please fill out both/all sections.

General Endocrinology Visit:

Welcome to West Michigan Endocrine. We are glad you're here. Endocrinology is the study of diseases associated with hormones and the organs that make them. For our patients who are coming to see us with issues related to the pituitary

any other condition not covered in the following sections, please fill out the information below.

What is the reason for your visit to an endocrinologist?

Do you have any specific questions for your provider?

Osteoporosis and other Disorders of Bone:

What is your diagnosis?

If you have osteoporosis, what treatments have you received?	When	Duration

What doses of Calcium and Vitamin D do you take?	How long have you taken them?

Fracture History?	Type		When		Type		When		

Did either of your parents fracture a hip or have other fractures?	No	☐	Yes	☐	Type:	

For women, tell me your menstrual history:

When was your last period?	Did you have regular periods when you had them?

Did you ever go through periods greater than 3 mo without getting a period?

When was your last bone density?

Did you ever take steroids (prednisone, dexamethasone, hydrocortisone) for longer than 2 weeks?

Do you have any of the following diagnosis or issues:

Rheumatoid arthritis	☐	Kidney stones	☐	Problems with absorption	☐
Vit D Deficiency	☐	Chronic Diarrhea	☐		

Anything else that you think we should know, please note it here:

Do you have any specific questions for your provider?

Thyroid Disease										
Note to our potential thyroid patients. We practice traditional endocrinology. We spend a lot of effort getting to know you and your symptoms and then follow the Endocrine Society, American Thyroid Association and the American Association of Clinical Endocrinology guidelines to decide upon treatment strategies for you. We may consider armour/desiccated thyroid medication in some cases and bases dosage needs on TSH levels. We do not prescribe compounded thyroid hormone preparations. We do not check reverse T3 levels and do not routinely follow free understand if this approach does not fit what you want for your thyroid management. There are many alternative medicine and naturopathic medicine providers in West Michigan if you would prefer an alternative approach to the management of your thyroid condition. Thank you.										
What is your diagnosis?										
Have you had any recent thyroid tests?					What were the results?					
Have you had a thyrid ultrasound?				Scan?		Uptake?		Radioactive Iodine treatment?		
If yes to any of the above, please bring results to your appointment.										
Have you ever had surgery on your thyroid?				If yes, where?				When?		
Have you ever taken thyroid medication?				If yes, when did you start?				Starting dose?		
				Current dose?						
Have you ever taken other types of thyroid hormone?										
For women, when was your last pregnancy?										
Are you planning to conceive within the next 12 months?										
Please indicate if you taking any of the following medications/supplements:										
Iron	☐	Iodine	☐	Kelp	☐	Amiodarone	☐	Birth Control pills	☐	
Estrogen	☐	Drugs for treatment of cancer		☐						
Do you have any specific questions for your provider?										

Type 2 Diabetes		
Welcome to West Michigan Endocrine. We are glad you're here. At this time, we are not seeing patients with type 1 diabetes or those		
When as your diabetes diagnosed?		
Who else in your family has diabetes?		
What was your last A1c?		
Do you follow a particular diet?	Do you exercise?	
What type of glucometer do you have?		When did you last see an eye doctor?
Have you ever seen a foot doctor and if so when was your last visit?		
Do you have any specific questions for your provider?		