Medical Intake Form

1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Current weight _____ Current Height _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Emergency contact _____ Relationship to emergency contact _____

Phone number of emergency contact _____

2. Preferred Language:

○ English ○ Spanish ○ Other

If other, please specify: _____

3. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

If other, please specify: _____

4. Ethnicity:

☐ Hispanic/Latino(a) ☐ preferred not to answer

Health Insurance

5. Do you have Medical Insurance?

○ Yes ○ No

6. Primary Insurance

Primary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

Do you have secondary insurance?
○ Yes ○ No

7. Secondary Insurance

Secondary Insurance Company | Member ID / Policy # | Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Street Address | Insured City | Insured State | Zip Code

8. Please bring insurance card and valid ID at time of appointment

Endocrinology Consult

9. What is the Primary reason for your visit?

- ☐ Diabetes Type 1
- ☐ Diabetes type 2
- ☐ Other type of Diabetes
- ☐ Prediabetes
- ☐ Insulin Resistance
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Thyroid Nodules
- ☐ Thyroid Cancer
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Hirsutism (Excessive facial hair growth)
- ☐ PCOS
- ☐ Menopause (Hot Flashes)
- ☐ Adrenal Disorder
- ☐ Adrenal tumor (Adenoma)
- ☐ Pituitary Disorder
- ☐ Hyperprolactinemia (Elevated Prolactin)
- ☐ Male Hypogonadism (Low testosterone)
- ☐ Erectile Dysfunction
- ☐ Osteoporosis
- ☐ Weight Management/ Obesity
- ☐ Hypercalcemia (elevated Calcium)
- ☐ Parathyroid disorder
- ☐ Vitamin D deficiency
- ☐ Neuroendocrine Tumor
- ☐ Hyperlipidemia
- ☐ Other Endocrine Disorder
- ☐ Unexplained Symptom's

10. review of system

- ☐ weight gain
- ☐ neck pain
- ☐ vision changes
- ☐ weight loss
- ☐ difficulty swallowing
- ☐ tingling numbness
- ☐ fatigue
- ☐ tremor /shakes
- ☐ muscle cramps
- ☐ dizziness
- ☐ difficulty in sleep
- ☐ low libido
- ☐ excessive thirst
- ☐ racing of heart
- ☐ erectile dysfunction
- ☐ excessive urination
- ☐ excessive sweating
- ☐ abnormal facial hair
- ☐ rash / discoloration of skin
- ☐ diarrhea
- ☐ irregular menstrual cycle
- ☐ headache
- ☐ constipation
- ☐ hot flushes

list any other symptoms you want us to know which is not listed above

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(Please check what symptoms are you currently experiencing)

Imaging /Lab Work

11. Please write date of lab work or imaging done related to today's visit. bring copies of lab or imaging if available.

Past Medical & Surgical History

12. Past Medical History (Check all that apply)

- ☐ Hypertension
- ☐ High Blood cholesterol
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Cardiovascular Disease
- ☐ Atrial Fibrillation
- ☐ Inflammatory Bowel Disease
- ☐ Iron Deficiency Anemia
- ☐ COPD
- ☐ Asthma
- ☐ Gall Stones
- ☐ Other

13. Past Surgical History (Please list any previous surgeries if applicable)

_____

_____

_____

_____

14. Family History (Please list any medical conditions your family members have)

_____

Medication List

15. Medication List (Please List any medications you are currently taking, including any supplements)

	Medication	Dose	Frequency

16. Do you have any drug allergies?

☐ Yes ☐ No

_____ _____

17. Have you ever used Biotin? If yes please mention dose and frequency.

☐ Yes ☐ No

_____ _____

Health Information

18. Please list individuals (and relationships) with whom you allow us to share your health information:

	Name	Relationship
1		
2		
3		

Social History

19. Smoking & Drinking questionnaire

Have you ever smoked?

○ Yes ○ No ○ Past

If past, date quit: _____ Packs/Day: _____ Years: _____

Do you drink alcohol?

○ Yes ○ No ○ Past

If past, date quit: _____

Have you ever felt a need to cut down on your drinking?

○ Yes ○ No

20. Have you ever used recreational drugs?

○ Yes ○ No ○ Past

21. What is your current occupation ?

_____

22. Are you Physically Active > 30 min/day:

- ○ Yes
- ○ No

23. If yes, how many times per week:

- ○ 5 or more times per week
- ○ 3-4 times per week
- ○ 1-2 times per week
- ○ Less than 1 time per week

Release of medical records

24. I authorize the release of information including the diagnosis, records, examination, treatment rendered to me and claims information. This information may be released to: Great Plains Endocrinology & Diabetes Care LLC.

Authorization

Signature

Date