LANCASTER ENDOCRINOLOGY
INFORMATION FOR YOUR PHYSICIAN

Today's Date: _____

Name:_____ DOB:_____

1.**LIST YOUR CHIEF COMPLAINT FOR TODAY'S VISIT:**_____

□ Self-referred or □ Consultation requested by Dr. _____

My Primary Care Provider is Dr. _____

2.**Family History** **(please note which side of the family: i.e. maternal grandmother, paternal aunt, maternal grandfather)**:

Diabetes who? _____ Heart Attack who?_____
Thyroid who? _____ Kidney failure who?_____
High blood pressure who? _____ High cholesterol (lipids)who?_____
Stroke who?_____ Cancer (type)_____who?_____

3. **Medical Problems *You*** have had: (please **circle** and **include date** diagnosed where applicable)

□ Diabetes date:_____ □ Osteoporosis □ High Blood Pressure Date:_____
□ Stroke date:_____ □ Peptic Ulcer Disease □ Heart Attack Date:_____
□ Kidney Failure □ Reflux Escophagitis □ Chronic Lung Disease
□ Gout □ Depression □ Thyroid Disease Date:_____
□ Cancer Type:_____ date:_____ □ Other:_____

4. List previous **operations** (dates, hospital, name of surgeon, list left or right where applicable i.e left leg, right eye)

_____
_____

5.Do you use **tobacco**?

□ Yes, I currently use tobacco: Year started?_____ What kind?_____ Daily Amount?_____
□ No, I do not use tobacco: Former Use? □ No or □ Yes: Year Quit?_____ Former Daily Amount?_____
Current **Tobacco/Smoke Exposure**? □ none □ minimal □ frequent □ daily

6. Do you drink **alcohol**?

□ Yes Year started?_____ What kind?_____Daily Amount?_____
□ No In the past?_____ Year Quit?_____ Daily Amount?_____

7. Do you use **drugs**?

□ No □ Yes What kind:_____

8. **Race:** (please check):

□ American Indian or Alaska Native □ Asian □ Black or African America □ White
□ Native Hawaiian □ Other Pacific Islander □ More than one race

9. **Ethnicity:** (please check):

□ Hispanic or Latino □Not Hispanic or Latino □ Refused to report

10. **Diabetic Patients**:

Date of last Eye Exam:_____

11. **Vaccines:** (*In agreement with CDC guidelines, we recommend diabetic patients over the age of 6 months get an annual flu vaccine.)

Year of last Flu Vaccine_____ Year of last Pneumonia Vaccine_____