Endocrine and Metabolic Specialists, LLC

Patient Health History Update

Time of Arrival:_____
Time of checkout:_____

NAME: _____ **Date**_____

1. Change of address? Yes / No _____

2. Change of phone numbers? Yes / No _____

3. Change of Insurance? Yes / No_____
(If yes, please hand over card to the front desk)

4. **Do you need a chaperone for this visit?** Yes/No_____

5. **Name of your Primary Care Physician** _____ **Date of Last Physical** _____

6. **Pharmacy Name and city** _____

7. **Have you had a recent blood work? If yes, WHICH DR's office OR LAB DID YOU GO TO?** _____

8. **Since your last visit with us have you:** **DATE:**_____

   i. Had any surgery? Yes / No. If yes:_____

   ii. Any new health problems diagnosed? Yes / No. If yes: _____

If female, are you pregnant? Yes / No.

If you are DIABETIC:

1. Have you had a recent dilated eye exam? Yes /No. Date of exam _____
2. Have you had a recent foot exam? Yes /No Date of exam _____
3. What blood sugar monitor (meter) do you use? _____
4. How many times a day do you check your blood sugars? 1 2 3 4 5 6 7 _____.

Important note regarding prescriptions:

1. *Please ask the doctors and/or office staff for prescriptions or refills of your medications while you are here at the office to reduce errors in handling prescriptions after the visit. We give enough refills to last you until your next visit.*

2. *Please understand that obtaining prior authorizations for medications is a very involved and time consuming process. We try to get the medications authorized in the best interest of our patients and we have allocated one person for doing this. However, our resources are very limited.* PLEASE HELP US BY CHECKING WITH YOUR INSURANCE TO FIND OUT WHAT MEDICATION IS COVERED. *Prescribing covered medications may be the best solution. At any point of time we can give you the necessary documentation to pursue the authorization yourself with your insurance company. Thank you for your cooperation.*

DO YOU NEED PRESCRIPTIONS OR REFILLS? YES/ NO. If yes, LIST THE MEDICATIONS BELOW:

QUESTIONS FOR THE DOCTOR:

Date:_____ Signature of Patient: _____

Please use the back of the sheet if you need more space to answer any of the questions.

Do you have an advanced directive or a living will? Yes /No. If yes, please give a copy to the receptionist.