Endocrine & Diabetes Consultants

Abdul Al-Kassab M.D, Ph.D | Abdallah Dlewati, M.D. | Lima Lawrence, M.D.

Patient History Form

Patient's Last Name: _____ First Name: _____

Patient's Date of Birth: ____/____/_____ **Allergies**: _____

Briefly Describe What Problem Brings You to the Doctor: _____

_____

Patient Medical History: **Please check inside the area if you have ever had any of the following:**

☐ Diabetes	☐ High Cholesterol	☐ Cancers	☐ Strokes
☐ Thyroid	☐ Osteoporosis	☐ Heart Disease	☐ High Blood Pressure
☐ Urine Infection	☐ Lung Disease	☐ Kidney Stones	☐ Autoimmune Disease: _____

Medications, Current: **Please list them out:**

1	2
3	4

Past Surgical Medical History: **Please check inside the area if you have ever had any of the following:**

☐ Amputations	☐ Heart Surgery	☐ Hysterectomy:
☐ Other:		

Social History: **Please check inside the area if you have ever had any of the following:**

Tobacco Use: If yes, packs per day:	Alcohol Use: Number and type of drinks per day:

Past Family Medical History: **Please check inside the area if you have ever had any of the following:**

☐ Diabetes	☐ High Cholesterol	☐ Cancers	☐ Strokes
☐ Thyroid	☐ Osteoporosis	☐ Heart Disease	☐ High Blood Pressure
☐ Urine Infection	☐ Lung Disease	☐ Kidney Stones	☐ Autoimmune Disease: _____

System Review: **Please check inside the area if you have ever had any of the following:**

1. Has there been any recent weight change?	☐ Yes	☐ No
2. Do you wake up at night to go to the bathroom?	☐ Yes	☐ No
3. Do you have any chest pain/shortness of breath?	☐ Yes	☐ No
4. Do you have any tingling/numbness in your feet?	☐ Yes	☐ No
5. (For Women): Do you have irregular menstrual cycles?	☐ Yes	☐ No

For Diabetics: **Please check inside the area if you have ever had any of the following:**

1. Do you have any history of eye disease or damage due to diabetes?	☐ Yes	☐ No
2. Did anyone tell you that there was/is protein in your urine?	☐ Yes	☐ No
3. Do you have a glucose meter? If Yes, what kind:	☐ Yes	☐ No

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Patient Information Sheet

Last Name: _____ First Name: _____

Patient's Date of Birth _____/_____/_____ ☐ Male ☐ Female S.S. # _____-_____-_____

Address: _____ City _____ State_____ Zip_____

Primary Phone # ☐ Home ☐ Cell (_____) _____-_____ Other (_____) _____-_____

Email Address _____

Primary/Family Dr _____ Phone # (_____) _____-_____

Name of Doctor who referred you _____ Location City _____

Pharmacy Name: _____ Location _____ Phone # (_____)_____-_____

Emergency Contact _____ Phone # (_____) _____-_____

Important General Information:

1. I understand and accept that I will be financially responsible for all deductibles, co-payments, co-insurances, and non-covered charges as provided by my insurance. If my insurance plan requires a valid referral to receive medical care, I understand that **it is my responsibility to provide such a referral**. If my referral is determined to be invalid by my insurance carrier, I understand that I will be financially responsible for balances on my account including non-covered items. If my insurance plan is not accepted by this office or is of the indemnity type, I understand that I am financially responsible for all balances remaining after payment, if any, made by my insurance plan. I hereby authorize the physician and/or their representative(s) to release any and all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

2. We request that you provide us with at least 24 hour notice before canceling any future appointments, failure to do so may incur a **$20.00 cancellation fee**.

3. All balances and **co-pays are expected at the time of your visit**. If a statement is sent due to non-payment there is will be a **$5.00 statement charge**.

_____ _____-_____-_____

Signature Date