ENDOCRINOLOGY CONSULTANTS, P.C.
DIABETES & THYROID CENTER OF NJ

229 Engle Street Englewood, NJ 07631
201.567.8999 • Fax: 201.567.5385
www.endocrinewellness.com

199 Engle Street Englewood, NJ 07631
201.567.8008 • Fax: 201.567.3003
www.endocrinewellness.com

Endocrinology Consultants is pleased to take part in your medical care. Listed below are some phone numbers and information.

Appointment Date: _____ **Time**: _____

PLEASE BE HERE 15 MINUTES BEFORE YOUR APPOINTMENT TIME

Directions to the office:

From GEORGE WASHINGTON BRIDGE and NJ-4 WEST:

Merge on to **NJ-4 WEST** toward **PARAMUS**. Take **GRAND AVENUE** ramp toward **ENGLEWOOD**. Continue on **GRAND AVENUE / CR-501** for 1.4 miles. **GRAND AVENUE** becomes **ENGLE STREET**. End at **199 ENGLE STREET/229 ENGLE STREET** (199 ENGLE ST: Office building is located on the right side of the street. Small parking lot is located in back of the building. 229 ENGLE ST: Office building is located on the right side of the street. For parking turn right on Hamilton Road).

From PATERSON area and NJ-4:

Merge onto **NJ-4EAST**. Take the ramp toward **GRAND AVENUE/ENGLEWOOD** (second Englewood exit). Turn RIGHT onto **ROCKWOOD PLACE** for 1 mile. Turn RIGHT onto **GRAND AVENUE / CR-501.** Continue to stay on **GRAND AVENUE** for 1.6 miles. **GRAND AVENUE** becomes **ENGLE STREET**. End at **199 ENGLE STREET/229 ENGLE STREET** (199 ENGLE ST: Office building is located on the right side of the street. Small parking lot is located in the back of the building. 229 ENGLE ST: Office building is located on the right side of the street. For parking turn right on Hamilton Road).

Test Results:

New patients please bring any blood work or scans that have been done in the last 6 months for your initial visit. The test results will be reviewed with you at your visit. If you have missed your appointment, please be sure to reschedule.

Prescription Refills:

Call your pharmacy first. If you need a written prescription, contact our office at 201-567-8999. Please allow one week for prescriptions to reach you by mail.

Billing Questions:

For billing questions about your doctor's bills, please call the billing department at 1-201-567-8999. Please make sure if you require a referral it is valid for the day of your visit.

Patient's Personal Information **Marital Status**: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Sex: [ ]Male [ ] Female

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____ Apt #: _____

City: _____ State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Email Address: _____ Date of Birth: _____/_____/_____

Social Security#: _____ - _____ - _____

Patient's / Responsible Party Information **Relationship to Patient:** [] Self [] Spouse [] Child [] Other: _____

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)

Date of Birth: _____/_____/_____ Social Security#: _____ - _____ - _____

Home Address: _____ Apt #: _____

City: _____ State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Patient's Insurance Information * Please present insurance cards to receptionist. *

Relationship to insured : [] Self [] Spouse [] Child [] Other: _____

PRIMARY Insurance Name: _____

Address: _____City: _____ State : _____ Zip Code: _____

Name of insured: _____ Date of Birth: _____/_____/_____

Policy #: _____ Group #: _____ Co-pay : $ _____

Relationship to insured : [] Self [] Spouse [] Child [] Other: _____

SECONDARY Insurance Name: _____

Address: _____City: _____ State : _____ Zip Code: _____

Name of insured: _____ Date of Birth: _____/_____/_____

Policy #: _____ Group #: _____ Co-pay : $ _____

Patient's Referral Information

Referred by**:** _____ Phone: (_____)_____- _____

Patient's Primary Medical Doctor

Name: _____ Phone: (_____)_____- _____

Patient's Other Medical Doctors

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Pharmacy Information

Name: _____

Address: _____City: _____State : _____ Zip Code: _____

Phone: (_____)_____- _____ Fax: (_____)_____- _____

Emergency Contacts

Name: _____Relationship _____

Address: _____City: _____State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Name: _____Relationship _____

Address: _____City: _____State : _____ Zip Code: _____

Home Phone: (_____)_____- _____ Work Phone: (_____)_____- _____ Cell Phone (_____)_____- _____

Assignment of Benefits – Financial Agreement

I herby give lifetime authorization for payment of insurance benefits to be made directly to Endocrinology Consultants, P.C. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I herby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Signature: _____

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Referral information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits that my appointment may have to be rescheduled.

Initial_____

Insurance information – Co-payments and deductibles

Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collection, interest and/or a collection fee at the provider's current rate of 18% may be charged on all balances owed the provider that are past due. Your signature below signifies your understanding and willingness to comply with this policy.

Initial_____

Cancellation/No Show Policy

Please be aware that if you No Show or Cancel two appointments there will be a charge of $25.00. We require 24 hours notice.

Initial_____

Insurance Cards

New patients or those patients with changes in their insurance information must provide a valid insurance card or temporary printout at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by initialing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Initial_____

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Endocrinology Consultants, PC (provider) from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the name provided below, please ask the receptionist for a HIPPA Form.

Name of Individual (please print)	**Relationship to Patient**

Notice of Privacy Policy Patient Acknowledgement
I understand that under the Health Insurance Portability Accountability Act of 1998, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood the Notice of Privacy Policy for the above named Provider.

The Provider reserves the right to change the terms of the Notice or Private Policy. I understand the Provider will supply a current Notice or Private Policy upon request.

I certify that the information that I have provided is correct. I authorize the release of medical information if necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filling and payment of medical claims, I authorize payment of medical benefits to the Provider.

Signature: _____ Date: _____
(Signature of insured or authorized person, patient or parent of minor) (Today's Date)

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INSURANCE COVERAGE INFORMATION

In the past few years, the number of health insurance programs has increased at an amazing rate. Even within one company, there may be several plans with varying benefits, requirements, and specific restrictions unique to each plan. Many insurance plans restrict you to using only their affiliated hospitals for blood tests, x-rays or emergency room visits. In addition, these restrictions frequently change without notifications. Many insurance plans restrict you to using certain laboratories for blood and urine testing. Some insurance companies require referrals. There are companies that require pre-authorization for FNA Biopsies, MRI's, Bone Density Test, Thyroid Scans and Ultrasounds and others that do not. Some insurance plans will not cover services that have always been available to you. There are Insurance companies that may have pre-existing condition clauses.

We are sorry if this causes some inconvenience, but the complexities of todays health care system makes it impossible for us to know the details of every plan.

It is your responsibility to know and to advise us of your plan's requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance of your plan's requirements or conditions. Such as referrals or pre-authorizations or pre-existing condition clauses, and we provide a service or use a laboratory or consultant that is outside of the program, you will be responsible for the appropriate fees. Your insurance carrier should have provided you with a phone number to call if you have any questions about your coverage. Please be aware if your account is sent to collections there will be a charge of fifteen percent.

A new patient consultation that has to be cancelled or rescheduled please give the office a call 48 hours in advance or there will be a seventy five dollar charge.

If you miss, two appointments there will be a twenty five dollar charge.

I have read the above statement reqarding my responsibilities toward my insurance carrier and agree that I am ultimately responsible for any fees that are not covered by my insurance company.

Patient Name:_____

Parent/Guardian Signature:_____

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Osteoporosis: Can It Happen to You?

Osteoporosis is a major public health threat for 44 million Americans. Ten million individuals already have osteoporosis and 34 million more have low bone mass placing them at increased risk for developing osteoporosis and the fractures it causes. Eighty percert of those affected by osteoporosis are women. Known as “the silent thief,” osteoporosis progresses without symptoms pr pain until bones start to break, generally in the hip, spine, or wrist.

QUESTIONS	YES	NO
1. Do you have a small, thin frame and/or are you Caucasian or Asian?		
2. Have you or a member of your immediate family broken a bone as an adult?		
3. Are you a postmenopausal woman?		
4. Have you had an early or surgically-induced menopause?		
5. Have you taken high doses of thyroid medication or used glucocorticoids ≥5mg a day (for example, prednisone) for 3 or more months?		
6. Have you taken, or are you taking, immunosuppressive medication or chemotherapy to treat cancer?		
7. Is your diet low in dairy products and other sources of calcium?		
8. Are you physically inactive?		
9. Do you smoke cigarettes or drink alcohol in excess?		

The more times you answer “yes,” the greater your risk for developing osteoporosis.

Osteoporosis is a complex disease and not all of its causes are known. However, when certain risk factors are present, your likelihood of developing osteoporosis is increased. Therefore, it is important for you to determine your risk of developing osteoporosis and take action to prevent it now.

Osteoporosis is preventable if bone loss is detected early. If the questions suggest that you are at risk for developing osteoporosis, see your healthcare provider. Your healthcare provider may recommend that you have a bone mass measurement test. This test will safely and accurately measure your bone density and reliably predict your risk of future fracture.

If you already have osteoporosis, you can live actively and comfortably by seeking proper medical care and making some adjustments to your lifestyle, your healthcare provider may prescribe a diet rich in calcium and vitamin D, a regular program of weight-bearing exercise and medical treatment.

The national osteoporosis foundation (NOF) is the nation’s leading authority for patient and healthcare providers seeking up-to-date, medically sound information and educational materials of the causes, prevention, detection and treatment of osteoporosis.

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Neuropathy

Date: _____

Patient Name: _____ **Date of birth:** _____/_____/_____

Please indicate which of the following symptoms you experience:

Symptom	Side of the body (Please check off box)			
Back and Leg Pain	**Right**	**Left**	**Both**	**None**
Pain in your lower back	[ ]	[ ]	[ ]	[ ]
Pain in you buttocks	[ ]	[ ]	[ ]	[ ]
Pain or burning in your leg	[ ]	[ ]	[ ]	[ ]
Numbness or tingling in your legs	[ ]	[ ]	[ ]	[ ]
Weakness in your legs	[ ]	[ ]	[ ]	[ ]
Loss of strength in you legs	[ ]	[ ]	[ ]	[ ]
Foot Pain	**Right**	**Left**	**Both**	**None**
Pain or burning in your feet	[ ]	[ ]	[ ]	[ ]
Numbness or tingling in your feet	[ ]	[ ]	[ ]	[ ]
Feels like pins and needles in your feet	[ ]	[ ]	[ ]	[ ]
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	[ ]	[ ]	[ ]	[ ]
Trouble feeling hot or cols in your feet	[ ]	[ ]	[ ]	[ ]
Trouble feeling your feet when you walk	[ ]	[ ]	[ ]	[ ]
Discomfort or pain at night in your feet	[ ]	[ ]	[ ]	[ ]
Hand, Finger or Wrist Pain	**Right**	**Left**	**Both**	**None**
Pain or burning in your fingers	[ ]	[ ]	[ ]	[ ]
Numbness or tingling in your fingers	[ ]	[ ]	[ ]	[ ]
Difficulty gripping things with your hands	[ ]	[ ]	[ ]	[ ]
Difficulty forming a fist with your hands	[ ]	[ ]	[ ]	[ ]
Discomfort in hands wakes you at night	[ ]	[ ]	[ ]	[ ]
Diabetes Mellitus				
Do you have diabetes? [ ] Type 1 [ ] Type 2 [ ] No How long have you had diabetes? _____				

Patient Signature: _____

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Name of patient (print): _____

I hereby acknowledge and confirm that, by signing this Assignment of Benefits, I have requested medical treatment, diagnostics and/or other medical or healthcare services (the "Medical Services") from Endocrinology Consultants P.C. ("Endocrinology Consultants") on behalf of myself and/or my dependents. Furthermore, I acknowledge and agree that I am fully financially responsible for any and all fees and payments associated with any and all Medical Services rendered to myself and/or to my dependents (the "Fees"), including without limitation, any co-pays and deductibles. The Fees shall be charged, and payment in respect of such Fees are due, on the date the Medical Services that are the subject of such Fees are rendered. **In the event that the insurance company sends a check to me for any services rendered, I will forward the payment to Endocrinology Consultants, P.C.**

Additionally, I acknowledge and agree to each of the following:

1. I hereby assign to Endocrinology Consultants any and all payments and benefits (each such payment or benefit, a "Benefit") of any kind whatsoever to which I, or any of my dependents, are entitled to (or have actually received), whether it be from a private insurance provider, government source (including, without limitation, Medicaid and/or Medicare) or any other third-party payer (any of the above payment and benefit sources, an "Insurance Provider"), in connection with the Medical Services.
2. Any Fees that are due and payable for over [sixty (60)] days shall accrue interest at the rate established by applicable New Jersey State law for such overdue payment. I understand that if a balance is unpaid, my account may be referred to a collection agency and/or a legal office.
3. I hereby authorize and direct any and all Benefits that are due, pending or that I am in any way entitled to, from any Insurance Provider in connection with the Medical Services, to be issued and paid directly to Endocrinology Consultants. This authorization fully applies to any and all Fees regardless of whether Endocrinology Consultants is in-network or out-of-network with the Insurance Provider providing such Benefit(s).
4. I understand and agree that, regardless of any Benefit to which I, or any of my dependents, are entitled to or actually receive, I am fully responsible for any Fees due to Endocrinology Consultants in connection with the Medical Services, that have not been actually received by Endocrinology Consultants for any reason, including without limitation, due to a non-payment or claim denial by any Insurance Provider.
5. I agree to assist Endocrinology Consultants in their efforts to obtain payment for any Medical Services from any Insurance Provider. However, I fully understand that it is ultimately my responsibility to pay any and all Fees and to obtain any and all required authorizations and/or precertification(s) for any and all Medical Services.
6. I understand that no guarantees have been made by Endocrinology Consultants or any other party in respect of any Medical Services or whether the Fees associated with such Medical Services will be paid for by any Insurance Provider.
7. I hereby authorize Endocrinology Consultants to:
    i. release any information, in connection with the Medical Services, necessary or beneficial to receive any Fee, to any Insurance Provider or other relevant third-party;
    ii. process insurance claims in connection with the Medical Services; and
    iii. use a photocopy of my signature to process any and all insurance claims.
8. I acknowledge and confirm that I have received a copy of Endocrinology Consultants' Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

A photocopy of this assignment is to be considered as valid as the original. This Assignment of Benefits shall remain in full force and effect until there are no Fees owed to Endocrinology Consultants in connection with the Medical Services.

Name of person signing below (print): _____ **Relationship to insured:** _____

Signature of Insured or Parent/Guardian: _____ **Date:** _____

COMPREHENSIVE HISTORY AND PHYSICAL ENDOCRINOLOGY EVALUATION (FEMALE)

NAME_____, _____DATE BORN_____/_____/_____Age_____
(Last) (First) (Initial)

On the two lines below, please describe the problem for which you are seeing the doctor:

_____

_____

History of the present illness (HPI)

(PLEASE DO NOT WRITE IN THIS BOX)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Prescription medications, antacids, aspirin, supplements, vitamins, health products, or laxatives you are now taking:

Name of Medicine	Dose strength	When taken	To treat what	Year begun	Prescribed by

FAMILY HEALTH HISTORY:

(Such as heart disease, high blood pressure, stroke, cancer, diabetes, thyroid disease, mental illness)

Relationship to you	AGE IF STILL LIVING	IF NOT ALIVE, AGE PERSON DIED	DISEASES PERSON HAS OR HAD AND CAUSE OF DEATH IF DECEASED
Mother			
Father			
Brother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Sister			

PERSONAL AND SOCIAL HISTORY:

Where were you born? _____With whom do you live now?_____

Children (give sex and age in years)_____

Circle one: Married Divorced Widowed Remarried Never Married

Present weight: _____pounds The most you ever weighed (not pregnant):_____pounds

Has your weight changed in the past year? Gained _____pounds Lost _____pounds

Reason for weight gain or loss: _____

Your height: _____inches If you have lost height, how much? _____inches

Average number of hours you sleep each day ____hours

If you have trouble sleeping, what is the problem? _____

How many hours of exercise or heavy work do you do each week? ____hours

Amount and type of alcohol used each week:_____

Have you used "recreational" drugs (marihuana, heroin, crack). What?_____

If you have problems with your sexual function, what is the problem? _____

If you have used tobacco, what?_____ How much?_____

For how long? _____ years If you have quit, what year did you quit? _____

Highest education level you completed (circle one) GED High school College Graduate school

If you are on a restricted diet, what do you restrict?_____

If you drink caffeine beverages (coffee, cola, tea), how many ounces a day? _____ounces

What are your hobbies, recreational activities?_____

What is your current job?_____Your past jobs_____

If you served in the military service, give branch_____and years _____-_____

Religion (Catholic, Protestant, Jewish…)_____ Religious?_____

PAST MEDICAL HISTORY:

How healthy are you now (circle one): GOOD FAIR POOR

List drugs you are allergic to:_____

Year of last: Tetanus booster ____ Pneumococcal Vaccine ____ Flu Vaccine ____Hep B Vaccine ____

Check if you had rheumatic fever____ Malaria____ Other serious infections _____

PAST HOSPITAL ADMISSIONS & SURGERIES:

Year admitted	Cause of illness		Year admitted	Cause of illness

REVIEW OF THE SYSTEMS:

EYES, EARS, NOSE, THROAT (CHECK THOSE YOU HAVE)

Loss of hearing ____
Earache or drainage ____
Loss of balance or vertigo ____
Lightheadedness ____
Hoarseness ____
Loss of sense of smell ____
Sinus trouble ____
Constant or frequent nasal stuffiness ____
Loss of ability to taste food ____
Repeated nose bleeding ____
Chronic dryness of the mouth ____
Wear glasses or contacts ____
Blurred vision and glasses don't help____
Double vision ____
Glaucoma ____
Sense of something in the eyes all the time____
Year last saw dentist: _____ Name of dentist: Dr._____
Year last saw eye doctor: _____ Name of eye doctor: Dr. _____

LUNGS and HEART (CHECK THOSE YOU HAVE)

Short of breath even with little effort ____
Heart murmur ____
Wake up at night very short of breath ____
Exposed to tuberculosis____ Year _____ Treatment given? _____
Positive skin test for tuberculosis ____
Pain, discomfort, or tightness in chest ____
High blood pressure ____
Pain or lumps in breasts____
Breast biopsies ____
Persistent cough ____
Cough up blood ____
Cough up phlegm or sputum ____
Asthma ____
Palpitations or racing of the pulse ____
Repeated episodes of bronchitis ____
Drenching night sweats ____
Swelling of the legs or ankles ____
Severe pain in the calves while walking or running ____
Had an electrocardiogram (EKG) ____ Year of last one_____
Had a chest x-ray ____ Year of last one _____
Had a mammogram ____ Year of last one _____
Had an exercise or stress test ____ Year done _____

STOMACH, INTESTINES & LIVER (CHECK THOSE YOU HAVE)

Severe problem with stomach gas, bloating, or passing gas ____
Heartburn ____
Use antacids regularly ____
Frequent nausea ____
Have frequent or unexplained vomiting ____
Vomit blood ____
Stomach or abdominal pain ____
Bloody bowel movements ____
Loose bowels most of the time ____
Constipation most of the time ____
Hemorrhoids ____
Rectal pain or bleeding ____
Colon polyps ____
Ulcers ____
Had hepatitis or yellow jaundice ____

Had an Xray of the stomach ____
Had an endoscopy (a lighted tube exam) of stomach ____
Had a CAT scan or MRI of the abdomen ____
Had an X-ray or ultrasound of gallbladder ____
Had a lighted tube exam of the colon (sigmoidoscopy or colonoscopy)____
Had a barium enema Xray of the colon ____

KIDNEYS & BLADDER (CHECK THOSE YOU HAVE)

Had a kidney ultrasound or IVP ____
Get up at night just to urinate____ How many times a night? ____
Unable to control bladder and have accidents ____
Weaker and slower urine stream ____
Blood in urine ____
Kidney stone ____
Urinary, kidney or bladder infections ____
Venereal disease ____
Burning or pain during urination ____
Protein in urine ____
Constant feeling of a need to urinate ____
Trouble or hesitancy in getting urine flow going ____

SEXUAL ORGANS (FEMALE)

(CHECK IF THESE APPLY AND FILL IN THE BLANKS)

Number of times you have been pregnant ____
Number of miscarriages or abortions you have had ____
Number of children you delivered ____
Number of living children you have ____
Complications of pregnancy ___ What? _____
Age periods began: ____years
Had tubes tied ____
Had a hysterectomy ____
Had ovaries removed ____
Date last period began ____/____/_____
Periods are about every ____ weeks and last about____ days
Periods are abnormally heavy ____
Bleeding between periods ____
Had the menopause but am bleeding now ____
Severe cramps with period and use medication for these ____Medication used_____
Repeated episodes of vaginitis ____
Pain with intercourse____
Contraceptive use ____ If so, what do you use_____
Year of last PAP smear _____ Done by _____

MUSCLES, JOINTS & SKELETON (CHECK THOSE YOU HAVE)

Had fractures of bones____
Severe or unusual muscle cramps ____
Stiff joints____
Painful muscles ____
Swollen joints ____
Pain or stiffness in spine ____
Regular or repeated treatment for back ____ Treatment is by _____

NERVOUS AND PSYCHIATRIC (CHECK THOSE YOU HAVE)

Nervous breakdown ____
Psychiatric treatment ____ Treated by _____
Unusual weakness of muscles ____
Sick headaches ____
Numbness of part of body ____ Which part?_____
Paralysis in or loss of use of part of body ____ Which part?_____
Stroke ____
Pass out, fainting or loss of consciousness ____
Seizures or convulsions ____
Unusual shaking or trembling ____
Depressed ____
Easily annoyed or irritable____
Disturbed greatly by family___ By work ____ By other things ____
Considering suicide____ By what means?_____
Attempted suicide ____By what means?_____
Memory failing____

ENDOCRINE (CHECK THOSE YOU HAVE)

Big problem with heat or hot weather ____
Big problem with cold or cold weather ____
Excessive perspiration ____
Trouble swallowing ___
Goiter or enlarged thyroid gland ____
Nodule on thyroid gland ___
Tender thyroid or pain in the front of your neck ____
Excessive appetite ____
Poor appetite ____
Exhaustion or fatigue most of the time ____
Reduced libido or a poor sex drive____
Breast discharge ____
Change in voice ____
Excessive body or facial hair ____
Problem with acne____

OTHER PROBLEMS (CHECK THOSE YOU HAVE)

Pain in feet ____
Phlebitis____
Pulmonary embolus ____
Bleeder ____
Rash now or often ____
Chronic itching ____
Growth in the skin ____
Had or now have cancer ____Type?_____
Radiation therapy ____For?_____
Anemic ____
Swollen lymph glands ____

PATIENT: PLEASE DO NOT WRITE BELOW HERE

Date reviewed _____/_____/ 201__ by _____
Joseph J. Schwartz, MD, CNSP