



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 Ave).

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 Ave).

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.

Billing Questions:

For billing questions about your doctor's bills, please call the billing department at 1-201-567-8008. 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: (____) _____ - _____ Cell Phone: (____) _____ - _____
Email Address: _____ Date of Birth: ____/____/____
Social Security#: _____ - _____ - _____

Employer Information

Occupation: _____
Employer Name: _____
Address: _____ Suite/Unit #: _____
City: _____ State: _____ Zip Code: _____
Work Phone: (____) _____ - _____

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 (____) _____ - _____



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Assignment of Benefits – Appointment as Authorized Representative

I hereby acknowledge and confirm that, by signing this Assignment of Benefits (“AOB”), I have requested medical treatment, diagnostics and/or other medical or healthcare services (the “Medical Services”) from Endocrinology Consultants P.C. (“the Practice”) on behalf of myself and/or my dependents. I hereby assign all applicable health insurance benefits and payment (each such payment or benefit, a “Benefit”) and all rights and obligations that I and any of my dependents are entitled to (or have actually received), whether it be from a private insurance payor, government source (including, without limitation, Medicaid and/or Medicare) or any other third-party payor (any of the above payment and benefit sources, an “Insurance Payor”), in connection with the Medical Services to the Practice. This authorization fully applies to any and all fees regardless of whether the Practice is in-network or out-of-network with the Insurance Payor providing such Benefit. I hereby appoint the Practice as my authorized representative (my “Authorized Representative”) with the power to:

- ✓ File and process medical claims with the Insurance Payor.
- ✓ File appeals and grievances with the Insurance Payor.
- ✓ Discuss or divulge any of my personal health information or that of my dependents with any third party, including the Insurance Payor.
- ✓ Institute and pursue on my behalf any claim, right or cause of action, including any necessary litigation and/or complaints against the Insurance Payor (even to name me as a plaintiff in such action).
- ✓ Act with respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4) with respect to any healthcare expense incurred as a result of the Medical Services I received from the Practice and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy, including fines.

I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my bills for professional services from the Practice are paid in full. I also understand that I am 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, coinsurance and deductibles. I understand that no guarantees have been made by the Practice 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 Payor and that I have the right to receive care elsewhere. I understand that I am fully responsible for any Fees due to the Practice in connection with the Medical Services that have not been actually received by the Practice for any reason, including without limitation, due to a nonpayment or claim denial by any Insurance Payor. I agree to assist the practice in its efforts to obtain payment for any Medical Services from any Insurance Payor. However, I fully understand that it is ultimately my responsibility to pay any and all Fees and to obtain any and all required authorizations, referrals and/or precertification(s) for any and all Medical Services. If my insurance plan has a pre-existing conditions clause, or requires an authorization or referral and I do not obtain one for the Medical Services I receive, I understand that I am responsible for all Fees, even if the provisions of my plan stipulate I otherwise wouldn’t be. I understand that this AOB incorporates and supersedes any prior and contemporaneous understandings or agreements between the parties with respect to the subject matter of this AOB.

Authorization

I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above and certify that the information that I have provided is correct. This Assignment of Benefits shall remain in full force and effect until there are no Fees owed to the Practice in connection with the Medical Services.

I authorize the Practice to obtain the following governing plan documents for the purposes of applicability of compliance with PPACA: (1) Summary Plan Description (SPD); (2) 5500 Form (Plan Annual report); (3) Certified Copy of Certificate for PPACA Grandfathered Plan.

Patient Name (print):

Signature of Patient (or Parent/Guardian):

Name of Parent/Guardian (if applicable): _____ Relationship to Patient: _____ Date: _____



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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Endocrinology Consultants, P.C. (the “**Practice**”), and its staff and providers, may use and disclose my Protected health Information (“**PHI**”) to carry out treatment, payment and healthcare operations (“**TPO**”). I understand and acknowledge that the Practice’s Notice of Privacy Practices (the “**Notice**”) has a more complete description of such uses and disclosures.

I permit the Practice to leave e-mail, telephone and text messages regarding my appointments, prescription renewals, lab results, and all other PHI on voicemail systems, or to provide such information to the person(s) who answer the phone, using the contact information provided.

- I agree that my PHI may be shared with my spouse (if applicable)
- I agree that my PHI may be shared with the following other people:

_____ Relationship to Patient: _____

- I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to the Practice to the attention of the Privacy Officer. I understand and acknowledge that the Practice may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.
- I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that the practice can submit records to support its charges.
- I agree that the Practice may contact me at any phone numbers or email addresses provided by me regarding both PHI and non-PHI.

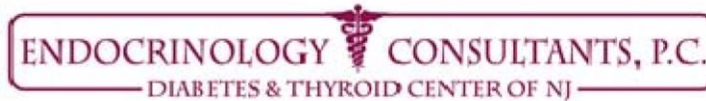
My signature below acknowledges that I agree with the above statements and have received the Practice’s Notice and/or have been provided with an opportunity to review it.

Signature of Patient

Date

Print Name

SPOUSE/HEALTH CARE POA/LEGAL GUARDIAN
(Please circle one if signing on behalf of the patient)



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FINANCIAL POLICIES

Registration: Upon scheduling and registration with Endocrinology Consultants, P.C. (the “Practice”), we require you to provide your medical insurance card (if you are utilizing its coverage, it must be brought to every visit), all third-party payor coverage information, photo identification, address, date of birth and phone number. If you receive health benefits through a spouse, partner or parent, we require you to also provide that person’s full address, date of birth, and phone number. For collection purposes, we also require social security numbers. Should you be unable to produce this documentation, you may pay in full at the time of service and submit the claim to your insurance plan for reimbursement. Please notify us of changes to your insurance coverage or contact information, otherwise you may be responsible for charges we were unable to recover.

Medicare: If you have coverage with Medicare (including both original Medicare and commercial Medicare Advantage plans), it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and coinsurance. Medicare Advantage beneficiaries may be responsible for an annual deductible, coinsurance and/or a copayment. Any portion of copayment, coinsurance and deductible which is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare coverage and also commercial insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below, you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding these provisions.

Commercial Health Insurance Plans: Although we will advise you whether we believe we participate with your insurance plan, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this Practice are covered by your plan. You and you alone are responsible to understand the provisions of your insurance plan and coverage. We recommend contacting your plan prior to receiving services in order to verify your financial responsibilities. If your insurance plan, including Medicare, issues payment to you instead of to us, you are responsible to turn the entire payment over to us immediately upon receipt together with the complete explanation of benefits form. You may be responsible for an additional balance, depending on how your insurance plan adjudicates such a claim.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan and assure it is presented at the time of your visit. If your plan requires a referral, precertification or authorization that you do not obtain, your appointment may have to be rescheduled. Otherwise, if as a result your health plan refuses to pay for any claim, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn’t be (you are waiving that defense). Further, it is also your responsibility to keep track of the number of visits you have used on your referral and the expiration date of your referrals and obtain new ones as needed. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours.

Cancellation/No Show Policy: If a new patient consultation has to be cancelled or rescheduled, please call the Practice forty-eight hours in advance or there will be a \$75 charge. If you miss two appointments there will be a \$25 charge.

Copayments, Coinsurance and Deductible: If your plan has a copayment, co-insurance or deductible, it is your responsibility to pay it at the time of service, even if the amount is not printed on your insurance card. Please have your payment ready upon check-in. We are out-of network healthcare providers with some health plans, meaning we have no contract with some health plans to participate in their network of participating providers and in many instances, they do not pay our charges for medical services in full. As a result, we have an obligation to bill our out-of-network patients their ordinary co-insurance, deductibles and cost share amounts as per your insurance agreement. If you fail to pay your coinsurance, deductibles or cost share amounts upon receipt of our invoice, you may be subject to collection activity and may be further responsible for the interest on the balance owed the Practice. However, we recognize that not all of our patients will be able to afford their patient cost share amounts. As a result, we have created a financial hardship policy which legally permits us to reduce, and in some cases, waive your patient cost share responsibility, if you qualify for the waiver. If you believe you might qualify, you may ask our staff for a copy of our financial hardship policy. Accordingly, you agree by signing this document to be responsible for your patient cost share amount, unless you qualify for financial assistance under the Practice’s financial hardship policy.

Non-Payment: Any fees that are due and payable for over thirty (30) days may accrue interest at the monthly rate of thirty percent (30%). I understand that if a balance is unpaid, my account may be referred to an external collection action.

I have read, fully understand and agree with all the above policies. I fully understand and accept my financial responsibility for the charges I, or my dependents, may incur at this office.

Patient Name (print): _____ Signature of Patient (or Parent/Guardian): _____

Name of Parent/Guardian (if applicable): _____ Relationship to Patient: _____ Date: _____

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) _____

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 (MEN)

(CHECK IF THESE APPLY AND FILL IN THE BLANKS)

- Prostate trouble _____
- Burning or discharge from penis _____
- Swelling, pain, tenderness, or a lump on testicles _____
- Trouble with erections _____
- Had a vasectomy _____

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 _____

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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 percent of those affected by osteoporosis are women. Known as “the silent thief,” osteoporosis progresses without symptoms or 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 $\geq 5\text{mg}$ 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)			
	Right	Left	Both	None
Back and Leg Pain				
Pain in your lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in you buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or burning in your leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of strength in you legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Pain				
Pain or burning in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feels like pins and needles in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling hot or cols in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling your feet when you walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort or pain at night in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand, Finger or Wrist Pain				
Pain or burning in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gripping things with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty forming a fist with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort in hands wakes you at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus				
Do you have diabetes? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> No				
How long have you had diabetes? _____				

Patient Signature: _____