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Endo Care of South Florida
Center for Endocrine and Diabetes Care

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# New Patient Registration Form

| Today's Date | | | |
|---|---|---|---|
| Full Legal Name (First) | Middle: | Last: | Other name used (i.e Maiden Name |
| Address: | | City, State, Zip | |
| Email address: | Home phone no: | Cell phone no: | Social Security no: |
| Date of Birth | Ocupation: | Employer: | Employer phone no: |

**To comply with goverment reporting, please mark which applies:**

Ethnicity ☐ Hispanic/Latino ☐ Other

Race ☐ White ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ American Indian/Alaska Native

Language: ☐ English ☐ Spanish ☐ French ☐ Other

| Your Primary Doctor | Office Phone Number | Office Fax Number | Addresss |
|---|---|---|---|
| Your Pharmacy | Phone Number | Address | |

## INSURANCE INFORMATION

| Primary Insurance Company Name | Group No. | ID/Certificate No. |
|---|---|---|
| Subscriber Name: | Subscriber's Birth date: | |
| Secondary Insurance Company Naqme | Group No. | Group No. |
| Subscriber Name: | | |
| Other Insurance Information | | |

## EMERGENCY INFORMATION

| Name of local relative or friend : | Relatoship to patient | Home phone no.: | Cell no. |
|---|---|---|---|

## MAY WE CONTACT YOU?

I wish to be contacted in the following manner :

Primary Phone: _____

Email Address: _____

Other: _____

The above information is true to the best of my knoledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am finally responsible for any balance. I also authorize Endo Care of South Florida and/or, Ihosvani MIguel, MD, PA or insurance company to release any information required to process any claim.

**Patient/Guardian signature**:_____

**1. How often do you exercise on average week?**

☐ 0-2 days ☐ 3-5 days ☐ 6-7 days

**2. Duration of your exercise/walk/biking per session?**

☐ 0-30 Min ☐ 31-60 Min ☐ More than 1 hr.

**3. Describe your diet (what you eat on a daily basis**

**4. Do you presently smoke/use tobacco?**

◯ Yes ◯ No How many packs a day?

**5. Have you ever smoked?**

◯ Yes ◯ No Whed did you quit?

**6. Do you currently consume more than 2 alcohol drinks a day?**

◯ Yes ◯ No

## I need to see Endocrinologist for :

**7. I have the following medical conditions**

1. _____
2. _____
3. _____
4. _____
5. _____

**8 .I had the following surgeries or was hospitalized for:**

1. _____
2. _____
3. _____

**9. I'm allergic to the following medications:**

| | Medication | Allergic Reaction |
|---|---|---|
| 1. | | |
| 2 | | |
| 3. | | |

Date of Last Physical Exam (month/year)_____

Date of Last Eye Exam (Month/Year_____

Date of Last Foot Exam (Month/Year)_____

Date of Last Dental Exam (Month/Year)_____

**10. I Am taking the following medicines, vitamins, supplements, herbs (name, dose, frequency):**

1._____
2._____
3._____
4._____
5._____
6._____
7 _____
8._____
9._____
10._____

## Family History

**11. Do your parents or brothers/sisters/children have or had (*Circle all that apply):***

a. Heart attack/Heart Bypass surgery/Stent : Yes No Don't Know

b. Stroke? Yes No Don't Know

c. High Cholesterol? Yes No Don't KNow

d. Obesity? Yes No Don't Know

e. Adult Diabetes? Yes No Don't Know

f. Juvenile, Type 1 Diabetes? Yes No Don't Know

g. Thyroid Disease? Yes No Don't Know If yes, what kind? _____

h. Cancer? Yes No Don't Know If yes, what organ did it start? _____

i. Osteoporosis, Hip fracture? Yes No Don't Know

j. Rheumatoid Arthritis, Lupus, Multiple Sclerosis, ALS? Yes No Don't Know

**Reason for Visit:**

**Please mark any of the following symptoms that you are having:**

**General:** ☐ Unexplained weight change ☐ Fatigue ☐ Fever

**Eyes:** ☐ Eye Laser Treatment ☐ Cataracts ☐ Retinal Detachment ☐ Poor Vision/Blindness ☐ Glaucoma

**Ent.:** ☐ Changes in Voice, Hoarseness ☐ Difficulty Swallowing ☐ Enlarged Thyroid or Neck Lumps ☐ Pain in Front of the Neck

**Heart/ Respiratory:** ☐ Asthma or CORP ☐ Sleep Apnea ☐ Shortness of breathon Exertion ☐ USE CPAP/BIPAP ☐ Slow, Fast, or Irregular Heart Beat ☐ Short of Breath at Night/Rest ☐ Ankle/Leg Swelling ☐ Pacemaker or Internal Deibrillator ☐ Long Term Cough ☐ Poor Healing Leg Ulcers

**Gastrointestinal:** ☐ Nausea/Vomiting ☐ Frequent Heartburn, Indigestion ☐ Irritable Bowel ☐ Diarrhea or Constipation ☐ Food intolerances:

**Breast:** ☐ Nipple Discharge ☐ Breast Pain/Tenderness or Swelling

**Blood:** ☐ History of Blood Clots ☐ Bleeding Problems ☐ Easy Bruising

Have you ever had radiation treatments to head, neck or whole body? ◯ Yes ◯ No

**Urological:** ☐ Frequent Bladder or Vaginal infections ☐ Frequent Urination ☐ Kidney Stones

**Men Only:** ☐ Pain or Lump in Testicles ☐ Change in desire to have sexual intimacy (libido) ☐ Difficulties achieving or mantaining erection

**Women Only:** ☐ Irregular Periods ☐ Vaginal Dryness ☐ Date of Last Period: ☐ Are you currently pregnant? ◯ Yes ◯ No

**Musc/Bones:** ☐ Gout ☐ Arthritis ☐ Fractures ☐ Amputations

**Neuro/Psych:** ☐ Frequent Severe Headaches ☐ Unsteady Gait ☐ Dizziness ☐ Previous Head Injury ☐ Loss of Consciousness ☐ Memory Loss ☐ Seizures ☐ Tremor ☐ Depression/Anxiety/Fears ☐ Paralisis ☐ Decreased Sensation/Feet

**Endocrine:** ☐ Excessive Sweating/Night Sweats ☐ Thyroid Problems ☐ Pituitary Problems ☐ Calcium Problems ☐ Low Blood Sugar ☐ Heat/Cold Intolerance

**Skin:** ☐ Foot Leg Ulcer ☐ Skin Rash ☐ Hair Loss ☐ Darkening or Lightening of Skin ☐ Dry Skin

**Anything else you would like us to know about you?** _____

I hereby certify that the answers given are true and complete to the best of my knowledge. I hereby authorize Endo Care of South Florida and/or Ihosvani Miguel, MD, PA to release any information acquired in the course of my treatment to any physician or health organization as required.

**Signature:** _____

**Vitals**

Temp: _____ HT: _____

Pulse _____ WT: _____

Resp _____ BP: _____

For office use only: _____

Reviewed: _____