Weill Cornell Medical College

NewYork-Presbyterian Hospital
Weill Cornell Medical Center

Division of Endocrinology, Diabetes & Metabolism
Department of Medicine
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Dear patient:

If you are new to my practice, or if you have been a patient for many years, I want to welcome you to your visit. I want to take the opportunity to familiarize you with the way I run my practice so that I can ensure that every patient gets the attention, information, and care that they need.

- I pride myself on making every effort to see patients on time. Please make sure to arrive at least 10 minutes early for your appointment so that you, and all other patients, can be seen on time. Please note, if you are more than 10 minutes late for your appointment, you may be rescheduled to a different time that day, if time is available, or to a different day entirely.

- If you call in with a question, you will receive a call-back from me within one business day. If you do not hear from me, please call back. When leaving phone messages with the staff, please try to be as specific as possible about your question/request so that I can fully address your question.

- To ensure coordination of care, every patient must have a primary care physician. If you change to a different primary care physician, please let our staff know so that your records can be updated.

- If you do need to cancel or reschedule, please notify our staff as soon as possible. If all patients do this, it enables us to better accommodate patients in a timely manner. It is very important that you call 24 hours in advance to cancel your appointment. For example, if your scheduled appointment time is at 10am, you must call prior to 10am the day before to cancel or reschedule your appointment. If you fail to notify our office in time, your account will be charged $50.00. After three consecutive no-show occurrences, our practice may elect to terminate our relationship with you.

Thank you for reviewing the guidelines and I look forward to taking good care of you for many days to come.

Sincerely,

Division of Endocrinology

DIVISION OF ENDOCRINOLOGY, DIABETES, & METABOLISM
HEALTH HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MD NAME: _____ **DATE:** _____

I certify that the following information is accurate. I will not hold my physician or any members of his/her staff responsible for any errors or omissions made when completing this form.

Signature_____

What is your reason for visit? _____

Who is your referring physician? _____ Physician's phone #: _____

HEALTH HISTORY

PAST MEDICAL HISTORY Mark **(×)** all that apply.

☐ Acid Reflux Disease	☐ Chemical Dependency	☐ High Chol./High Triglycerides	☐ Pneumonia
☐ Alcoholism	☐ Depression	☐ HIV Disease	☐ Polio
☐ Anemia	☐ Diabetes	☐ Irregular Menstrual Periods	☐ Prostate Problem
☐ Anorexia	☐ Emphysema	☐ Kidney Disease	☐ Psychiatric Care
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Stroke
☐ Asthma/Lung Problem	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Bleeding Disorders	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bulimia	☐ Heart Disease	☐ Mumps	☐ Ulcers
☐ Cancer	☐ Hepatitis	☐ Osteoporosis/Osteopenia	☐ Vaginal Infections
☐ Cataracts	☐ High Blood Pressure	☐ Pacemaker	

SURGICAL HISTORY: List past surgeries and year. _____

_____

PAST HOSPITALIZATIONS: List reason and year. _____

_____

HEALTH HABITS Mark **(×)** what substances you use and describe how much you use.

X	HABIT	FREQUENCY
☐	Caffeine	
☐	Tobacco	
☐	Alcohol	
☐	Drugs	

FAMILY HISTORY Complete health information about your family.

RELATION	AGE	STATE OF HEALTH	AGE AT DEATH	CAUSE OF DEATH	MARK (×) IF APPLIES TO BLOOD RELATIVE	RELATIONSHIP TO YOU
Father					☐ Diabetes	
Mother					☐ Thyroid Disease	
Brothers					☐ High Blood Pressure	
					☐ Heart Disease	
					☐ Stroke	
					☐ Breast Cancer	
Sisters					☐ Ovarian Cancer	
					☐ Prostate Cancer	
					☐ Colon Cancer	
					☐ Osteoporosis	
					☐ High Chol/High Trig	

PATIENT NAME: _____ **DATE OF BIRTH:** _____

SOCIAL HISTORY Mark **(×)** all that apply.

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Living Situation: ☐ Alone ☐ Partner ☐ Parents ☐ Children (# of children ____)
☐ Other: _____

Occupation: ☐ Student ☐ Retired ☐ Unemployed ☐ Employed ☐ Job Title:_____

SYMPTOMS Mark **(×)** symptoms that pertain to you.

GENERAL	☐ Weight loss	☐ Weight gain	☐ Excessively tired	☐ Discomfort
	☐ Chills	☐ Sweats	☐ Loss of appetite	☐ Fever
EYES	☐ Blurring	☐ Double vision	☐ Irritation	☐ Discharge
	☐ Eye pain	☐ Vision loss	☐ Intolerance of light	☐ Swelling
GASTROINTESTINAL	☐ Indigestion/Heart Burn	☐ Diarrhea	☐ Constipation	☐ Nausea
	☐ Change in bowel habits	☐ Excessive gas	☐ Stomach pain	☐ Vomiting
NEUROLOGIC	☐ Temporary paralysis	☐ Tremors	☐ Numbness/Tingling	☐ Dizziness
	☐ Loss of Consciousness	☐ Seizures	☐ Headache	☐ Weakness
RESPIRATORY	☐ Shortness of breath	☐ Cough	☐ Coughing up blood	☐ Snoring
	☐ Coughing up sputum	☐ Wheezing	☐ Rectal bleed/bloody stool	
PSYCHIATRIC	☐ Depression	☐ Suicide thoughts	☐ Mental disturbance	☐ Paranoia
	☐ Anxiety	☐ Hallucinations	☐ Memory loss	
EARS/NOSE/THROAT	☐ Sore Throat	☐ Ear discharge	☐ Loss of hearing	
	☐ Ringing/Buzzing in ears	☐ Nosebleeds	☐ Nasal Congestion	
	☐ Difficulty swallowing	☐ Hoarseness	☐ Earache	
CARDIOVASCULAR	☐ Chest pain/pressure	☐ Swelling of ankles	☐ Loss of consciousness	
	☐ Irregular heart beat	☐ Shortness of breath	☐ Varicose veins	
MUSCULOSKELETAL	☐ Back pain	☐ Muscle cramps	☐ Stiffness	
	☐ Joint pain	☐ Muscle weakness	☐ Arthritis	
ENDOCRINE	☐ Cold intolerance	☐ Frequent thirst	☐ Increased urination	
	☐ Heat intolerance	☐ Increased hunger	☐ Weight loss or gain	
GENITO-URINARY MEN ONLY	☐ Painful urination	☐ Frequent urination	☐ Erection difficulties	
	☐ Blood in urine	☐ Poor bladder control		
	☐ Breast lump	☐ Decreased sex drive		
GENITO-URINARY WOMEN ONLY	☐ Vaginal discharge	☐ Painful urination	☐ Breast lump	
	☐ Poor bladder control	☐ Blood in urine	☐ Decreased sex drive	
	☐ Frequent urination	☐ Breast lump	☐ Irregular menstrual period	
	☐ Decreased sex drive	☐ Pelvic pain	☐ Absent menstrual period	
ALLERGIC/ IMMUNOLOGIC	☐ Skin conditions	☐ HIV exposure	☐ Persistent infections	
	☐ Hay fever	☐ Enlarged lymph nodes		
HEME/LYMPHATIC	☐ Abnormal bruising	☐ Bleeding		
SKIN	☐ Rash	☐ Dryness	☐ Suspicious wounds	
	☐ Itching			

ALLERGIES: List any allergies to medications.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICATIONS: List current prescription medication amount and time taken or provide list if you have one.

NAME OF MEDICATION	DOSAGE AMOUNT	TIME TAKEN

SUPPLIMENTS/VITAMINS: List current supplements/vitamins taken or provide list if you have one.

NAME OF MEDICATION	DOSAGE AMOUNT	TIME TAKEN

PHARMACY:

Name: _____

Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

☐ May we fax prescriptions to your pharmacy? (Mark (x) box if ok)