St. Peter's Health
MEDICAL GROUP
ENDOCRINOLOGY

New Patient Paperwork
Andeelyn Wardell, NP
Endocrinology
2550 East Broadway - POD 1D

Appointment: _____
Arrive: At _____ if paperwork is filled out*
At _____ if paperwork is NOT filled out*
***If you are late for your appointment, you will be asked to reschedule out of consideration of our other patients**

Welcome and thank you for choosing St. Peter's Medical Group. We want to do everything we can to address your health care needs and make your first visit comfortable and convenient.

The enclosed paperwork is necessary for us to get an accurate assessment of your particular condition. Please complete this packet to the best of your knowledge and bring it in with you at the time of your appointment.

At this initial visit, you are asked to ***bring in all of the current prescriptions and over the counter medications, or a current list of all the medications you are currently taking. If you are a diabetic, please bring or list any diabetic supplies (i.e. test strips, meter, and insulin pump supplies) that you are using with you to your appointment. That way we have the correct information in your chart and makes re-ordering an easier process.

***__**If your appointment is in regards to your diabetes, we strongly encourage that you upload and print your device reports at home and bring the printout with you to your appointment.**__ If you are unable to do this at home please bring your glucometer, insulin pump, or continuous glucose monitor to appointment and give it to our front staff when you check in. This way we can download the information beforehand and have it ready at the time of your visit

*** Any needed lab work will be ordered at your appointment.

*** It is the patient's responsibility to contact their insurance to verify coverage for a specialist.

You will be asked to provide a photo ID and your current insurance card(s). If your insurance policy requires a co-pay, you will be asked to provide payment for each office visit. If you have no insurance, a $75 payment is required at the time of your visit. If you have any questions, please feel free to call our office at **(406)495-6841** and we will be happy to assist you. We are looking forward to meeting you!

Name: DOB:

Endocrinology: Current Symptoms

CIRCLE ALL THAT APPLY

Constitutional:

appetite change excessive sweating fatigue night sweats weight gain weight loss
other:_____

Eyes:

blurred vision corrective Lenses eye irritation eye pain spots in vision vision loss
double vision bulging of eye peripheral vision change dry eyes other:_____

Ears, nose, mouth, throat:

nasal discharge mouth lesion hoarseness change in smell nasal congestion
other:_____

Cardiovascular:

chest pain dec. exercise tolerance palpitations dizziness cramps in legs leg ulcers
peripheral edema Shortness of Breath: lying down other:_____

Respiratory:

cough snoring wheezing shortness of breath shortness of breath with exercise
other:_____

Gastrointestinal:

abdominal pain bloating nausea vomiting difficulty swallowing change in bowel habits
constipation diarrhea pale stools early satiety other:_____

Genitourinary:

sexual dysfunction absence of menstrual period abnormal menstrual periods abnormal vaginal bleeding
painful intercourse urgency incontinence urination at night infertility vaginal dryness
other:_____

Musculoskeletal:

back pain joint pain joint swelling limited range of motion muscle aches
muscle weakness stiffness height loss increase in ring/shoe/hat size
other:_____

Skin:

hair changes itching rash breast masses bruises bleeding redness
changes in skin color/texture other:_____

Neurologic:

headache numbness seizures slurred speech tremor burning in feet
other:_____

Psychiatric:

anxiety decreased concentration irritability panic attacks sadness/tearfulness
other:_____

Endocrine (male):

Excessive thirst excessive hunger excessive urination breast development

Endocrine (female):

abnormal menstrual pattern excessive thirst excessive hunger excessive urination flushed
hot flashes breast discharge other:_____

Blood/Immune system:

bruising bleeding tendencies lymphadenopathy recurrent infections
other:_____

Name: DOB:
Primary Doctor:_____

Referring Doctor:_____

Personal Medical History Circle all that apply

Eyes, Ears, Nose Cataracts Recurrent ear infections Glaucoma Recurrent sinusitis

Other _____

Endocrine Diabetes Hyperthyroid Graves disease Hypothyroid Parathyroid

Pituitary Calcium Problems Other _____

Respiratory Allergies/hay fever COPD Asthma Sleep Apnea

Other _____

Cardiovascular Chest Pain Heartburn Deep venous thrombosis Hypertension

Atrial Fibrillation Heart Failure Heart Attack Cardiac Arrhythmias Heart valve disease

Peripheral vascular disease Coronary artery disease High Cholesterol

Other_____

Gastrointestinal Colitis Liver disease Peptic ulcer disease GERD Pancreatitis

Irritable Bowel Other _____

Genitourinary Kidney disease Gonorrhea Kidney failure Urinary incontinence

Genital Herpes Kidney stones Erectile dysfunction Testicular problems Undescended testicle

Prostate problems Other _____

Musculoskeletal Arthritis Gout Fractures Osteoporosis

Other _____

Cancer Type _____

Chemo Radiation Surgery Currently under Treatment Remission

Infectious Disease AIDS Chickenpox Mumps Hepatitis Tuberculosis HIV

Rheumatic Fever Other _____

Skin Acne Psoriasis Eczema Other _____

Name: DOB:

Neurologic ADHD Headaches Seizure Stroke Dementia

Peripheral Neuropathy TIA Developmental Delay Restless Leg Syndrome

Other _____

Psychiatric Anorexia nervosa Bulimia Insomnia Anxiety Depression Bipolar

Schizophrenia Other _____

Metabolic/Genetic Cystic Fibrosis Down Syndrome Turner's Syndrome Klinefleter's Syndrome

Other _____

Events Anaphylaxis MVA Gun wound Other _____

Disabilities Hearing deficit Hemiparesis Quadriplegia Vision deficit Paraplegia

Other _____

Surgeries

Ears, Eyes, Nose

Cataract Tonsillectomy Other _____

Endocrine

Parathyroidectomy Thyroidectomy Other _____

Respiratory

Bronchoscopy Lobectomy Other _____

Cardiovascular

Angiogram Carotid endarterectomy Pacemaker Angioplasty Coronary stent

Valve Replacement CABG (Bypass) Heart Transplant

Other _____

Gastrointestinal

Appendectomy Colectomy Splenectomy Gallbladder Gastric Bypass

Other _____

Name: DOB:

Genitourinary

Bladder Nephrectomy Kidney stone Prostate TURP

Other _____

Reproductive

Vasectomy Hysterectomy Oophorectomy C-Section Tubal Ligation

Other _____

Musculoskeletal

Joint replacement: _____ Other _____

Skin

Skin cancer Other _____

Neurologic

Craniotomy Spinal Other _____

Breast

Biopsy Mastectomy Lumpectomy Other _____

If you are Diabetic:

- When were you diagnosed? _____
- When was your last diabetic eye exam? _____
- Do you see a podiatrist for your feet? Yes / No
    - Who?_____ When?_____
- When was your last A1C? _____Results?_____
- Have you ever met with a Diabetes Educator? Yes / No
    - If so when? _____ where? _____
- If you are on an insulin pump, what type? _____
- Do you use a Continuous Glucose Meter? What type? _____

Name: DOB:

Family Medical History - list family members, relationship to you, age of onset

Diabetes - _____

Thyroid - _____

Asthma - _____

High Cholesterol - _____

Hypertension - _____

Atherosclerosis - _____

Coronary Artery Disease - _____

Cancer (type) - _____

Hepatitis B - _____

Tuberculosis - _____

Dementia - _____

Stroke - _____

Alcoholism - _____

Depression - _____

Drug abuse - _____

Mental illness - _____

Autoimmune disease - _____

Blood disorder - _____

Rheumatoid disease - _____

Hearing problems - _____

Vision problems - _____

Name: DOB:

Tobacco Use

Do you currently use tobacco products? (Cigarettes, Chewing tobacco, e-cigarettes, etc.)	☐ No	☐ Yes	
Did you use tobacco products in the past?	☐ No	☐ Yes	Year started: Year quit:
If current or past use:	Type:		
	Amount:		
	How often:		
	For how many years:		
If you use tobacco products:	☐ I'm not ready to quit	☐ I would like help to quit	

Alcohol Screening (AUDIT-C)

In the past *3 months*…		**0**	**1**	**2**	**3**	**4**
1.	How often did you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
2.	How many drinks did you have on a typical day when you were drinking?	1-2	3-4	5-6	7-9	10+
3.	How often did you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4.	How often have you used marijuana?	Never	Not monthly	Monthly	Weekly	Daily or almost daily
5.	How often have you used an illegal drug or prescription medication for non-medical reasons?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
	Score					
		Total Score:				

In the past Month, have you had any thoughts of suicide or ending your own life? ☐ Yes ☐ No

Name: DOB:

Pharmacy (Local **and** Mail Order): ____

Medication Allergies & Adverse Reactions (**also list the reaction**):

____

____

Medication/Supplement	Dose	When do you take it? (i.e. once a day, twice a day, as needed)
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____
______________________	____________	____