GREENWAY ENDOCRINOLOGY, PA
DIABETES, ENDOCRINE, THYROID

PRIVIA
MEDICAL GROUP

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NEW PATIENT REGISTRATION FORM

Referring Doctor: ______________________________ Primary Care Doctor: ______________________________

Name: ____, ______________________________________ ________
Last First Mi

DOB: ________________________ SSN: __________ - ______ - __________ Legal Sex: ○Male ○Female

Address: ____

City: ____ State: __________ Zip: ________________

Home Phone: ______________________

Cell Phone: ________________________

Work Phone: _______________________

Email: ____

Race: ○Asian ○Black or African American ○Pacific Islander ○White ○Other ○Decline

Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed ○Decline

Employer: ____

Emergency Contact: ________________________ Phone: __________________ Relationship: ________________

INSURANCE INFORMATION (Please Provide Insurance Card)

HEALTH HISTORY

PATIENT NAME____ BIRTHDATE ___/____/____

Please fill out this form completely in ink. This is a confidential record and will be kept in this office.

Highest level in school ______________________________
Occupation______________________________
Marital status______________________________
Smoking (amount per day)______________________________
If former smoker, date quit______________________________
Alcohol (amount per week)______________________________

Chief Complaints Please list the present health concerns, symptoms, or problems you are experiencing:

____
____
____
____

Please list any serious illnesses or operations you have experienced and indicate year these occurred:

____
____
____
____

Past Medical History Have you ever had the following:

Heart Disease	no	yes	High Cholesterol	no	yes	Stroke	no	yes
Diabetes	no	yes	High blood pressure	no	yes	Kidney Disease	no	yes
Cancer	no	yes	AIDS / HIV	no	yes	Thyroid Disease	no	yes

Family History Has any blood relative had any of the following:

			Relationship
Cancer________	no	yes	________________
Diabetes ________	no	yes	________________
Heart Disease ________	no	yes	________________
High blood pressure ____	no	yes	________________
Stroke ________	no	yes	________________
Thyroid Disease ________	no	yes	________________
High Cholesterol ______	no	yes	________________
Kidney Disease ________	no	yes	________________

Review of symptoms Do you have now or have you had within the past year: (Circle "no" or "yes", leave blank if uncertain)

Weakness or Fatigue	no	yes	Difficulty swallowing	no	yes
Weight gain	no	yes	Nausea	no	yes
Weight loss	no	yes	Vomiting	no	yes
Change in appetite	no	yes	Frequent urination	no	yes
Sensitivity to cold/heat	no	yes	Increase in thirst	no	yes
Sweats or hot flashes	no	yes	Lack of sex drive	no	yes
Skin rash	no	yes	Joint pain or stiffness	no	yes
Change in nails or hair	no	yes	Muscle cramps or spasms	no	yes
Headaches	no	yes	Sleeplessness	no	yes
Blurred vision	no	yes	Memory loss	no	yes
Hoarseness	no	yes	**Men only:** Impotence	no	yes
Shortness of breath	no	yes	**Women only**: Irregular cycles	no	yes
Chest pain or discomfort	no	yes	How many days do periods last? ________________		
Swelling of hands, feet or ankles	no	yes	How many days between periods? ________________		
Palpitations or fluttering of the heart	no	yes	Do you bleed or spot between periods?	no	yes

______________________________________ ______________________________________

Signature of patient (or parent if minor) Date

MEDICATION LIST

NAME:____ **DOB:**____________

DRUG ALLERGIES: ____

NAME	DOSEAGE	FREQUENCY