NEW PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information is completely confidential and will not be released unless you authorize us to do so.

66 Gruene Park Drive Unit 210
New Braunfels, TX 78130
Phone: (830) 730-4375
Fax: (830) 730-4203

PERSONAL INFORMATION **Please provide a form of identification (Driver's License)				
Last Name	First	Sex M F Middle	Prefix	Birthdate
Mailing Address	City	State	Zip Social Security Number	
Home/Mobile Phone	Email Address			
Emergency Contact	Relationship	Home/Mobile Phone	Work Phone	
Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed		Number of Children:	Occupation:	

INSURANCE INFORMATION IF DIFFERENT FROM ABOVE **Please provide a copy of the Insurance Card(s)		
Name of Person Responsible for Insurance Account:		Relation to Patient:
Birthdate:	Soc. Sec. Number:	Insurance Company(ies)

MEDICAL HISTORY ***Check conditions you have or have had in the past***			
□ Adrenal insufficiency	□ Hyperthyroidism	□ Diabetes: Type _____ Duration _______	□ Osteoporosis
□ Adrenal tumor	□ Diabetes eye problems	□ Hypopituitarism	□ Pituitary tumor
□ Anemia or blood problems	□ Foot ulcer	□ Hypothyroidism	□ Polycystic ovaries
□ Arthritis	□ Heart disease/attack	□ Inherited disease: ___________________	□ Pre -Diabetes
□ Asthma	□ High blood pressure	□ Kidney disease/stones	□ Sleep apnea
□ Bone fracture(s)	□ High cholesterol	□ Mental illness	□ Stroke
□ Metabolic Syndrome	□ HIV/AIDS	□ Cancer/Tumor: _____________________	□ Thyroid nodule(s)
□ Morbid Obesity	□ Hypercalcemia	□ COPD, emphysema, lung disease	□ Thyroid cancer

REVIEW OF SYSTEMS ***Select condition(s) you are currently experiencing***							
Weight loss	Weight gain	Easy bruising	Fatigue	Acne	Tremor	Sleep disorder	Fevers or Chills

Patient Name____ Date of Birth____________ Today's Date____________

Excessive thirst	Headaches	Chest pain	Dizziness	Muscle pain	Hoarseness	Constipation	Diarrhea
Night sweats or Flushing	Palpitations (heart racing)	Blurred or double vision	Breast tenderness	Milk discharge from breasts	Muscle weakness	Nausea and vomiting	Shortness of breath or cough
Excessive hair growth	Hair loss	Irregular periods	Sexual issues (loss of interest or erections)	Numbness or tingling	Depression or Anxiety	Difficulty with urination	Difficulty swallowing

For Women: Age at first period:_____ Date of last period: _______________ Birth control method: __________________
Pregnancies: Live Births: ___ Miscarriages: ___ Abortions:___ Are you planning to have more pregnancies? □ Yes □ No

Primary Care Physician:	**Other Physicians:**

Reason for Visit:

ALLERGIES	
No Known Allergies	Yes, I have the following medication allergies and the following reaction.

HOSPITALIZATIONS & SURGERIES		
YEAR	LOCATION	REASON FOR HOSPITALIZATION / DESCRIBE SURGERIES

MEDICATIONS ***List all medications, vitamins, and supplements. Write dosage and frequency for each medication. *Please attach additional sheets if necessary.***

Are you testing your blood sugar? Y/N If so, how many times a day? _________________________________
What are your blood sugar results?
AM Fasting: ____ 2 HRS after breakfast: ____ Before lunch: ____ 2 hours after lunch: _____ Before dinner: _____ Before bed: _____
Are you using a continuous glucose monitor or insulin pump? Y/N If so, which one? _______________________

Preferred Pharmacy & Address:	Phone:
Secondary Pharmacy & Address:	Phone:

Patient Name____ Date of Birth____________ Today's Date____________

Health Maintenance History ***Record last date and result***	
Mammogram:	Eye exam:
Bone Density Testing:	Pneumovax23: Prevnar13:
Pap Smear or Prostate Exam:	Influenza Vaccine:
Foot Exam:	Dental Exam:
Last Diabetes Education:	

Family Medical History ***Check appropriate medical conditions***	
Father Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Mother Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Brother Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Sister Alive: Y/N	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis
Other	□ Diabetes □ Low thyroid □ High thyroid □ High blood pressure □ High cholesterol □ Adrenal gland □ Calcium issue □ Pituitary □ Heart disease (age<45 for males and <55 for females) □ Thyroid cancer □ Kidney stones □ Osteoporosis

Health Habits ***Mark (X) conditions you use and how much/how many hours***		
Tobacco use:	Alcohol use:	Diet:
Illegal drug use:	Exercise:	Sleep:
Caffeine intake:	Level of Stress:	Hobbies:

**** Please review our Clinical Policies and Agreements****

Your signature below signifies that you have read and acknowledge the policies regarding:

1) Consent for Treatment
2) Financial Responsibility
3) Release of Information
4) Benefit Assignment
5) About Physician Assistants
6) Acknowledgement
7) Notice of Privacy Practices

I attest that the above information is correct to the best of my knowledge.

I also certify that I, and/or my dependent(s), have insurance coverage with the insurance(s) provided and assign all insurance benefits, if any, directly to the Diabetes Metabolic Wellness Center. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The clinicians assigned to the Diabetes Metabolic Wellness Center may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below:

____ ___________________________

Signature of Patient, Parent, Guardian, or Personal Representative Date

____ ___________________________

Printed name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for this clinician and its affiliates to communicate PHI to the person(s) or organization listed below as directed by the patient.

Patient Name: ________________________ Date of Birth: _________

Patient Address: ____

Patient Email address: _______________________________________

Home Phone: _______________________ Cell Phone: ___________________

1) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

2) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

3) Information may be disclosed and used by the listed person(s) or organization(s) to assist me:
Name:____

Relationship: □ Spouse □ Sibling □ Parent □ Child □ Agent/Broker □ Friend □ Organization

I understand that this consent will allow this healthcare clinician and its affiliates to use or disclose the protected health information described below. (Please check only one box).

□ Full Disclosure: Any protected health information this provider and its affiliates collect and maintain, including mental health, HIV, sexually transmitted diseases, health status, alcohol and substance abuse treatment records, and genetic testing. This also includes information on health treatment programs, plan information and caregiver resources with the person being authorized.

□ Limited Disclosure: **Identify what protected health Information is to be <u>excluded</u> from any disclosure**. Such as a medical condition or treatment information or a specific date range of services:

____

I understand:

- **This consent will expire in 24 months from the date of signature, unless I cancel it before that time. I can cancel this consent at any time by sending a written request to my provider.**
- **If I cancel the consent, it will not apply to information previously released with this consent. Once information is shared, this provider cannot prevent the person or organization that has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.**
- **I understand I am not required to sign this consent and that this provider and its affiliates cannot base treatment or payment decisions based on my decision to sign this consent form.**
- **Protected Health Information includes Medical, Dental, Pharmacy, Behavioral Health, Vision, and Long-Term Care.**

Individual or Legal Representative Signature ___________________________ Date: _____________

□ Individual □ Legal Representative (attach copy of authorization, ie MPOA, guardianship)