FLORIDA ENDOCRINOLOGY & DIABETES CENTER

Venkata Budharaju, M. D.
2763 1st Ave N, St Petersburg, FL 33713
8839 Bryan Dairy Road, Ste 110, Largo, FL 33777
Phone: 727-623-9913
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Thank you for choosing Florida Endocrinology and Diabetes Center.
We are delighted to welcome you and will make every
effort to serve you in a manner that will meet your expectations.

Please assist us by completing the attached forms and bringing them with you for your initial visit.

If you need to change or cancel this appointment, please call us so we can offer this date and time to another patient.

Please bring the following items with you to your scheduled appointment on: _____

If your insurance requires authorization please inform your primary physician. If we do not have a referral for this appointment, it will be rescheduled.

- **Any medical records from your referring or previous physician.**
- **Picture ID**
- **Insurance Card(s)**
- **A list of all of your medication that you are currently taking.**
- **Co-payment if applicable.**

If your appointment is scheduled for diabetes management you will also need to bring:

- Your glucose meter
- A two week record of your blood sugars

On behalf of our entire medical team, we would like to thank you for choosing Florida Endocrinology and Diabetes Center for your health-care needs.

FLORIDA ENDOCRINOLOGY & DIABETES CENTER

Patient Information

Name _____

SSN#_____ Gender ☐ Male ☐ Female DOB _____

Address _____

City _____ ST _____ ZIP _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____

Primary Care Physician: _____Phone:_____Fax:_____

Referring Physician: _____Phone:_____Fax:_____

Primary Language _____ Need Interpreter? ☐ Yes ☐ No Marital Status ☐ S ☐ M ☐ D

Ethnicity_____ Religion _____ Race _____

Emergency Contact _____Relationship _____ Phone _____

Preferred Pharmacy & Phone Number _____

Guarantor of Account ☐ Self ☐ Other: _____Relationship _____

Address _____ City _____ ST ___ Zip _____ Phone # _____

Insurance _____ ID# _____ Grp #_____

Subscriber: ☐ Self ☐ Other: _____Relationship _____

DOB _____ SSN #_____ Phone # _____

All information given is accurate. I give permission for Florida Endocrinology and Diabetes Center to contact me regarding practice information by the above methods.

Signature _____ Date _____

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Patient Name:_____ Today's Date:_____

Reason for visit:_____

PLEASE COMPLETE ONLY THE SECTION THAT PERTAINS TO YOUR VISIT

Section 1: Thyroid

___ Anxiety or depression
___ Constipation/diarrhea
___ Fatigue
___ Heat/cold intolerance
___ Milk discharge from breast
___ Sore throat
___ Swelling of leg
___ Vision change
___ Brittle nails
___ Clearing throat frequently
___ Hair loss
___ Hoarseness
___ Pain over thyroid
___ Sweating
___ Tingling around mouth/hands
___ Weight gain/loss
___ Coarse hair
___ Difficulty concentrating
___ Headache
___ Irregular periods
___ Palpitations
___ Swelling of eye or eye lid
___ Tremors

___ Other _____

Are you currently pregnant? Yes/No _____ Thyroid issues during prior pregnancies? Yes/No _____

Section 2: Thyroid Nodule

___ Cough
___ Hoarseness
___ Pressure over neck
___ Current or former smoker
___ Neck mass/nodule
___ Shortness of breath
___ Difficulty swallowing
___ Neck pain or tenderness
___ Sore throat

___ Prior radiation exposure to head/neck If yes, Date _____ Reason _____

___ Family history of thyroid cancer ___ Other _____

Please document any tests or treatments that you have previously experienced, then provide as much detail as possible so we can obtain your records. If you are unsure of an answer, please leave blank.

___ Ultrasound of thyroid _____
_____

___ Thyroid scan and uptake (this is a nuclear medicine test) _____
_____

___ Thyroid nodule biopsy (US-guided FNA) _____
_____

___ Thyroid surgery (removal of half or all of your thyroid) _____
_____

___ Thyrogen whole body scan (for thyroid cancer patients) _____
_____

___ Radioactive Iodine treatment either for thyroid cancer or overactive thyroid/Graves' _____
_____

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Section 3: Diabetes

At what age were you diagnosed? _____

___ Blurred vision ___ Headache ___ History of diabetes during pregnancy

___ Increased thirst ___ Tingling/numbness of hands/feet ___ Urinating frequently

How often do you check your blood sugars? _____ Glucometer make/model _____

Most recent eye doctor appointment _____ How often do you exercise? _____

Current/Prior foot ulcers? Yes/No _____ Podiatrist's name _____

Current/Prior kidney problems? Yes/No _____ Nephrologist's name _____

Current/Prior heart problems? Yes/No _____ Cardiologist's name _____

Section 4: Polycystic Ovarian Syndrome (PCOS)

At what age did you have your first period? _____ Was your period regular or irregular? _____

___ Acne ___ Facial hair or hair on belly ___ History of infertility ___ Family history of PCOS

Did you have Diabetes during any of your pregnancies? Yes/No _____

Section 5: Osteoporosis

Prior bone density test? Yes/No _____ Prior fracture? Yes/No _____ Year _____

Family history of osteoporosis? Yes/No _____ Family history of hip fracture? Yes/No _____

Have you lost height? Yes/No _____ How many inches? _____

Have you had kidney stones? Yes/No _____ Are you menopausal? Yes/No _____

Have you had prior radiation treatment for any cancer? Yes/No _____ For what? _____

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SOCIAL HISTORY:

Occupation:_____Education:_____

RISK FACTORS:

Do you use tobacco? YES QUIT: _____(year) NEVER

If currently smoking cigarettes, how many packs per day? _____

If currently smoking cigars, How many per week? _____

Do you drink alcohol? YES / NO How many drinks per day?_____

Do you drink Caffeine? YES / NO How many caffeinated beverages per day?_____

MEDICATIONS: List all medications you are currently taking:

Prescription medications	Dose	How often taken

Allergies to medications: _____

PAST SURGICAL HISTORY: Please list type and date of surgery

Surgical Complications YES / NO

Anesthesia Problems YES / NO

Bypass Surgery: _____

Pacemaker/Defibrillator_____

Stent/Angioplasty_____

Thyroidectomy_____

Other:

_____

_____

_____

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FAMILY HISTORY: Please circle all that apply

I am adopted Yes

Diabetes	Mother	Father	Both Parents	Brother	Sister
Thyroid Disease	Mother	Father	Both Parents	Brother	Sister
Thyroid Nodules	Mother	Father	Both Parents	Brother	Sister
Hyperthyroidism	Mother	Father	Both Parents	Brother	Sister
Hypothyroidism	Mother	Father	Both Parents	Brother	Sister
Alcoholism	Mother	Father	Both Parents	Brother	Sister
Anemia	Mother	Father	Both Parents	Brother	Sister
Arthritis	Mother	Father	Both Parents	Brother	Sister
Anxiety	Mother	Father	Both Parents	Brother	Sister
Asthma	Mother	Father	Both Parents	Brother	Sister
Blood Clots	Mother	Father	Both Parents	Brother	Sister
Depression	Mother	Father	Both Parents	Brother	Sister
Growth Develop/Disorder	Mother	Father	Both Parents	Brother	Sister
Headaches	Mother	Father	Both Parents	Brother	Sister
Heart disease	Mother	Father	Both Parents	Brother	Sister
Hypertension	Mother	Father	Both Parents	Brother	Sister
High Cholesterol	Mother	Father	Both Parents	Brother	Sister
Osteoporosis	Mother	Father	Both Parents	Brother	Sister
Cancer:_____	Mother	Father	Both Parents	Brother	Sister

Mother: ☐ Alive ☐ Deceased Age _____

Father: ☐ Alive ☐Deceased Age _____

Siblings: Brothers _____ Sisters _____

Children: Boys _____ Girls _____

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PAST MEDICAL HSITORY: Please circle all that apply

Depression	Blood Transfusion	Rheumatoid arthritis
Diabetes Type I	CHF	Retinopathy
Diabetes Type II	COPD	Seizure Disorder
Hyperlipidemia (High Cholesterol)	Coronary Artery Disease	Stroke
Hypertension (High Blood Pressure)	Crohn's Disease	TIA
Hyperthyroidism	Cushing's Disease	Thyroid Nodule
Hypothyroidism	GERD	Thyroid Cancer
Hypercalcemia	Gastroparesis	Vascular Heart Disease
Hypoglycemia	Neuropathy	Pituitary tumors
Kidney Stones	Cirrhosis	Peripheral vascular diseases (PVD)
Acromegaly	Hepatitis A	Osteoarthritis
Anemia	Hepatitis B	Cancer: _____
Anxiety	Hepatitis C	HIV
Asthma	Osteopenia	Other: _____
Autoimmune Disorder	Osteoporosis	_____

SYMPTOM REVIEW

Endocrine
- ☐ history of diabetes
- ☐ Sensitive to hot or cold
- ☐ excessive thirst
- ☐ Breast growth (men)

Skin
- ☐ Skin ulcer
- ☐ Excessive dry skin
- ☐ Excessive hair growth

Cardiovascular
- ☐ chest pain
- ☐ history of irregular beat
- ☐ palpations
- ☐ history of poor circulation
- ☐ leg swelling

Neurologic
- ☐ Burning pain in feet
- ☐ Numbness
- ☐ Tingling
- ☐ Frequent headache
- ☐ Tremor
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss
- ☐ fatigue

Urinary
- ☐ Difficulty Urinating
- ☐ Urination at night
- ☐ Poor libido

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Nausea
- ☐ Abdominal pain

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ double vision
- ☐ bulging eyes
- ☐ dry eyes
- ☐ sinus problems
- ☐ hoarseness

Lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in :
  - ☐arms or hands
  - ☐back or hips
  - ☐legs or feet
  - ☐neck or shoulders

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If you are a Diabetic, please complete the following questions (If not, please skip):

DIABETES QUESTIONNAIRE

1. In what year were you diagnosed with diabetes?: _____
2. Have you ever been hospitalized for Diabetic Ketoacidosis (DKA)? __ Yes __ No
3. Do you have a home glucose monitor?: __ Yes __ No How old is the monitor?: _____
4. How often do you check your blood glucose?: _____
5. What is your typical glucose reading you obtain before?:

   Breakfast: _____ Lunch: _____ Dinner: _____ Bedtime: _____
6. Have you ever experienced symptoms of low blood sugar?: _____ If yes, how often?: _____
7. Do you measure your blood glucose level when you get these symptoms?: _____

   If yes, at what blood glucose level do you get these symptoms?: _____
8. Have you ever been unconscious because of low sugar?: _____
9. Do you have any emergency glucagon (injection) kit?: _____
10. Has diabetes affected your eyes?: ____ Date of last eye appointment?: _____

    Who did you see?: _____
11. To the best of your knowledge, has diabetes affected your kidneys?: _____
12. Do you experience the following:

    ☐ Tingling in your hands/feet ☐ Vomiting ☐ Lightheadedness

    ☐ Diarrhea ☐ Weight loss
13. If you are on insulin, where do you give injections:

    ☐ Abdomen ☐ Arms ☐ Legs ☐ Buttocks
14. Have you ever attended diabetes teaching classes?: __ Yes __ No
15. Where and how long ago?:_____
16. Have you ever met with a dietitian?: __ Yes __ No

    Where and how long ago?: _____
17. How has your weight changed over the past year?: _____
18. Do you exercise regularly?: __ Yes __ No What type of exercise?: _____
19. <u>(Females only)</u> If you have been pregnant, were you a diabetic during pregnancy?:_____

    ☐ Do you currently use birth control?: _____

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