NEW PATIENT FORM FOR DR. HOPE SHIPMAN
NOT PART OF THE PERMANENT MEDICAL RECORD

PATIENT NAME_____**DATE**_____

Who is your PRIMARY CARE DOCTOR? _____
May we EMAIL results to you using our secure/encrypted email? yes ☐ no ☐

What EMAIL ADDRESS should we use?_____

PHARMACY info: Local pharmacy _____**Phone #**_____
Mail order pharm _____***Circle your main pharmacy.***
Main REASON for VISIT to ENDOCRINOLOGIST: *(Please circle)*

Diabetes ☐ Thyroid ☐ Pituitary ☐ Adrenal ☐ Calcium ☐ PCOS ☐ Hormones ☐ Other ☐
_____

List your top 3 *SYMPTOMS* that you would like to discuss today:

1. _____
2. _____
3. _____

List all the MEDICINES that you are taking regularly (including over-the-counter medicines):

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Are you ALLERGIC to any MEDICINES? Which ones?

_____

List any SURGERIES that you have had in the past. (Details are not necessary on this form)

_____

_____

Have you ever been in the HOSPITAL? Please list the reason or diagnosis and the approximate year. (Details are not necessary on this form)

_____

_____

Do *YOU* have any of these MEDICAL PROBLEMS & NAME OF TREATING DOCTOR

MEDICAL PROBLEM	**PHYSICIAN/PRACTITIONER**
1. DIABETES	_____
2. THYROID PROBLEM	_____
3. HIGH BLOOD PRESSURE	_____
4. HIGH CHOLESTEROL OR LIPIDS	_____
5. HEART PROBLEM	_____
6. LUNG PROBLEM	_____
7. STOMACH OR COLON PROBLEM	_____
8. CANCER	_____
9. ARTHRITIS (RHUMATALOGIC PROB.)	_____
10. OTHER	_____

Do you have a *BLOOD RELATIVE* that has any of these problems? *(circle all that apply)*

Heart Disease ☐ Cancer ☐ Diabetes ☐ High Cholesterol ☐ High Blood Pressure ☐ Thyroid Problem ☐

We are required to ask about TOBACCO use: (*Please circle best answer*)

Do you smoke cigarettes now? **Yes ☐ No ☐** How much per day? **less than 1 pack per day ☐**
1 pack per day ☐
More than 1 pack per day ☐

In your whole life, have you smoked a total of 10 packs of cigarettes? **☐ Yes ☐ No**
If "yes", when did you quit? _____
Do you use any other form of tobacco? **Yes ☐ No ☐**

Do you drink ALCOHOL? Yes ☐ No ☐ Approximately how many drinks *per week*? _____

What is your **WORK STATUS** at this time? Full time☐Part time☐Not Working☐Disabled☐

What is (or was) your main **OCCUPATION**?_____

How many hours per week do you **EXERCISE**?_____

What type of **EXERCISE** do you do?_____

Do you follow any type of special **DIET**? _____