Arkangel Endocrinology & Diabetes, PLLC

Name:	DOB:
Referring doctor:	PCP:
Reason for visit:	

Preferred Pharmacy: (If No Pharmacy Used, Please List A Pharmacy Near Your Place of Residence)

Local Pharmacy Name:	Address or Cross Streets:	Phone/Fax:
Mail Order Pharmacy:	Phone:	Fax:

Preferred Lab and Imaging: (If Unknown, Please Contact your Insurance Plan for Contracted Lab and Imaging)

Lab: ☐Sonora Quest ☐LabCorp ☐ Other (List Name):	**Address or Cross Streets:**	**Phone:** **Fax:**
Imaging: ☐SimonMed ☐SMIL ☐ Other (List Name):	**Address or Cross Streets:**	**Phone:** **Fax:**

Medications and Supplements: ☐ *Check Here If No Current Medications or Supplements*

Drug name	Dose	How Many Times A Day	Started

Allergies: (Please List Reaction If Applicable) ☐ *Check Here If No Current Allergies*

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Past Medical Conditions: ☐ *Check Here If No Past Medical Conditions*

☐ Anxiety	☐ Coronary Artery Disease	☐ Hyperlipidemia (Elevated Cholesterol)	☐ Muscle, Joint, Bone Problem
☐ Arthritis	☐ Depression	☐ Hypertension (Elevated Blood Pressure)	☐ Obesity
☐ Asthma	☐ Diabetes	☐ Hyperthyroidism	☐ Osteoporosis
☐ Birth Defects/ Inherited Diseases	☐ Fibromyalgia	☐ Hypothyroidism	☐ PCOS
☐ COPD	☐ Gout	☐ Kidney Disease	☐ Pituitary Disorder
☐ Cancer Type:	☐ Heart Disease	☐ Liver Disease	☐ Stroke
☐ Thyroid Problem Type:		☐ Other:	

Immunizations: ☐ *Check Here If No Recent Vaccinations* ☐ *Check Here for Vaccine Refusal*

Influenza Vaccine	Date Vaccinated:
Pneumonia Vaccine	Date Vaccinated:
Other:	Date Vaccinated:

Prior Surgeries: (Please List Date/Year If Applicable) ☐ *Check Here If No Past Surgeries*

Recent Hospitalizations: (Please Lis Reason, Date, Hospital Name and Location) ☐ *Check Here If No Recent Hospitalizations*

Diabetes Examination: ☐ *Check Here If No Diabetes Examination Has Been Performed Previously*

Exam Type	Provider's Name/ Practice Name	Address or Cross Streets	Phone and Fax
Eye Exam			
Foot Exam			

Diabetic Supplies*: **Diabetic Patient's Only***

Glucometer:	Test Strips:	Lancets:	Other:
Insulin Pump:	Infusion Set:	Reservoir:	Cartridges:
DME Company Providing Supplies:			
Continuous Glucose Monitor (CGM):	Reader/Receiver:	Censors:	Transmitter:
DME Company Providing Supplies:			

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Family History: ☐ *Check Here If No Family History* ☐ *Check Here If Adopted and Unknown*

Condition	Relation
☐Diabetes mellitus	☐Paternal ☐Maternal
☐Stroke	☐Paternal ☐Maternal
☐Heart disease	☐Paternal ☐Maternal
☐Heart attack	☐Paternal ☐Maternal
☐Hypertension	☐Paternal ☐Maternal
☐Pancreatic tumor/cancer	☐Paternal ☐Maternal
☐Pituitary tumor / cancer	☐Paternal ☐Maternal
☐Thyroid tumor/ cancer	☐Paternal ☐Maternal
☐Cancer	☐Paternal ☐Maternal
☐Parathyroid/ calcium problem	☐Paternal ☐Maternal
☐Celiac disease	☐Paternal ☐Maternal
☐Drug abuse	☐Paternal ☐Maternal
☐Alcohol abuse	☐Paternal ☐Maternal
☐Premature menopause	☐Paternal ☐Maternal
☐Osteoporosis	☐Paternal ☐Maternal
☐Hip fracture	☐Paternal ☐Maternal
☐Thyroid disease	☐Paternal ☐Maternal
☐Iron overload disease	☐Paternal ☐Maternal
☐Seizures	☐Paternal ☐Maternal
☐High cholesterol	☐Paternal ☐Maternal
☐Obesity	☐Paternal ☐Maternal

Social History:

Tobacco Smoking	☐ Never Smoker ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Some Day Smoker
Smoking How Much	☐ 1 Pack Per Week ☐ 2 Packs Per Week ☐ ¼ Pack Per Day ☐ ½ Pack Per Day ☐ 1 Pack Per Day ☐ 1 ½ Pack Per Day ☐ 2 Packs Per Day ☐ 3+ Packs Per Day
Smokeless Tobacco	☐ Never ☐ Former ☐ Current Snuff User ☐ Currently Chews Tobacco ☐ Current Moist Powder Tobacco User
Tobacco Years of Use	
E-Cigarette/Vape	☐Never ☐ Current User ☐ Former User