**TRI-COUNTY ENDOCRINOLOGY & NUCLEAR MEDICINE, P.C.**

**38731 MOUND RD, STE 200 STERLING HEIGHTS, MICHIGAN 48310 TEL. (586)939-8480 FAX (586)939-8487**

**NANCY J. ANDREWS. D.O., M.A.C.O.I., F.A.C.E. ERIC S. LANGER, D.O., F.A.C.O.I., F.A.C.E., C.C.D.**

 **AMY LUM TOBIN, D.O., F.A.C.O.I. Kelley Thomas, P.A. - C**

We have reserved\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for you to have a consultation with

Dr. Andrews Dr. Langer

Dr. Tobin Kelley Thomas, P.A. – C

 Brian Tsacoumangos, PA-C

**PLEASE MAIL BACK THE FORMS THAT YOU FILLED OUT BEFORE YOU APPOINTMENT, IF THERE IS NOT TIME THEN PLEASE BRING THESE WITH YOU AT YOUR APPOINTMENT TIME.**

PLEASE **ARRIVE 30 MINUTES BEFORE YOUR SCHEDULED TIME** TO ALLOW THE FRONT DESK TO HAVE PROPER TIME TO VERIFY ALL INSURANCES AND TO PREPARE YOUR CHART. Please take the time to fill out the enclosed forms completely. Failure to do so may delay your visit up to an hour or may need to be rescheduled.

Please obtain all testing from your referring doctor and/or primary care doctor and have them faxed to our office at least 1 week prior to appointment, including labs, ultrasounds, and any other results that pertain to your visit. Also if you had a Thyroid Scan we need you to bring in the actual films from the hospital where the test was performed.

Also, we ask that you **please bring** with you the following information:

1. Photo ID
2. All insurance cards
3. A updated medication list with the dose and frequency
4. A list of all doctors that you do see
5. A pharmacy phone number
6. **A referral IF ONE IS NEEDED. All Blue Care Network insurances need a referral for each and every visit. If one is not obtained by the time of your visit, we will need to reschedule your visit.**

Please plan on spending approximately 1-2 hours in our office for your initial visit. If you do need to cancel your appointment for any reason please contact our office 24 hours in advance. If you are scheduled for an appointment and do not arrive there will be a “No Show Fee” of $100 for new patients and a $50 fee for established patients, as this time takes away from other patients that need to be seen.

Should your laboratory testing require specimens to be sent to a specific laboratory, please inform our staff at the time of your blood draw and we will accommodate your request.

**For Diabetic Patients only:**

For your initial evaluation and upon all future care related appointments, our physicians require additional evaluative testing to help guide your care plan and your best course of treatment. The testing includes: CGMS (continuing glucose monitoring system) which is a glucose sensor you wear for 3-5 days and it continuously records interstitial glucose levels every 5 minutes, nutrition counseling with our office dietician and an RMR analysis (resting metabolic rate analysis) which determines how many calories you are burning when inactive and fasting.

**PLEASE REFRAIN FROM WEARING SCENTED PRODUCTS SUCH AS PERFUMES, LOTIONS, COLOGNES, AND AFTERSHAVE, AS A COURTESTY TO INDIVIDUALS WHO ARE ALLERGIC OR HAVE BREATHING DIFFICULTIES.**

Thank you.

**LOCATION**

**WE ARE LOCATED ON THE WEST SIDE OF MOUND, 1 BLOCK SOUTH OF 17 MILE ROAD IN A PLAZA CALLED DEERFIELD OFFICE PLAZA. IT WILL BE THE BUILDING IN THE BACK, SUITE 200.**

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**REGISTRATION FORM**

**Section I:** **Patient Information Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate Box: ⬜ Minor ⬜ Single ⬜ Married ⬜ Widowed ⬜ Separated ⬜ Divorced

Spouse or Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity:

 ⬜ Hispanic ⬜ Latino ⬜ Not Hispanic or Latino

Race:

⬜ African American ⬜ Asian ⬜ American Indian ⬜ Caucasian ⬜ Hispanic ⬜ Native Hawaiian ⬜ White ⬜ Other

**Primary Language:** ⬜ English ⬜ Spanish ⬜ Chinese ⬜ Italian ⬜ Arabic ⬜ French ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy name (long term):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy name (short term):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section II Doctor Information**

**Doctor who referred you to our office:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiologist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Podiatrist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OB/GYN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urologist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ophthalmologist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. Also I am aware of my insurance coverage in event that Tri County Endocrinology is not a provider with my insurance I will also be responsible for any medical services rendered. I also authorize Tri-County Endocrinology and/or my insurance company to release any information required to process my claims.

|  |
| --- |
|  |
| *Patient/Guardian signature:* |  | *Date:* |

|  |  |  |
| --- | --- | --- |
|  | **Over** |  |
|  |  |

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**HIPAA (Health Insurance Portability & Accountability Act)**

Dear Patient,

According to new HIPAA Federal Regulations, each patient must be assured that his or her medical records are held in the strictest confidence. In order for Tri-County Endocrinology and Nuclear Medicine, P.C. to comply with these regulations, we ask that you take a moment to complete the following questionnaire.

Your signature and initials are required where requested.

**What individuals such as family or friends may we discuss your medical history, test or lab results:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_

**What physicians or medical personnel may have access to your medical history?**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.(Initials)\_\_\_\_\_\_\_\_\_

May we leave a message on your machine regarding any test results? \_\_\_\_\_\_\_yes \_\_\_\_\_\_\_\_no

**Our office will leave messages your answering service regarding any appointments and/or scheduling issues.**

**I understand that Tri-County Endocrinology and Nuclear Medicine, P.C. will adhere to the regulations as outlined by HIPAA and will follow the guidelines as I have outlined them above.**

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATION RECORD**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Allergies** | **Medication Tolerance** |
| Are you sensitive to fragrances? ⬜ Yes ⬜ No |
|  |  |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication****List all prescriptions and over-the-counter medications, birth control, vitamins and herbs.** | **Dose** | **Frequency** | **How would you like your prescriptions filled?** |
| Office to send in to Pharmacy | Want a written RX |
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Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Health History Questionnaire**

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. MEDICAL ILLNESS/SURGERY**

**List all types of illnesses and surgeries, past and present, including dates.**

|  |
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 ***Smoking Status:***

⬜ Current, everyday How Much: \_\_\_\_\_\_\_\_\_

⬜ Current, Some days How Much: \_\_\_\_\_\_\_\_\_

⬜ Quit, When: \_\_\_\_\_\_\_\_ How Much: \_\_\_\_\_\_\_\_

⬜ Non-Smoker

**B. SOCIAL HISTORY**

***Employment:***

⬜ Disabled ⬜ Full time ⬜ Part time

⬜ Self ⬜ Retired ⬜ Homemaker

⬜ Student

 ***Marital Status:***

⬜ Single ⬜ Married ⬜ Separated

⬜ Divorced ⬜ Widowed

***Use of Alcohol:***

⬜ Never ⬜ Rarely ⬜ Moderately

⬜ Occasionally ⬜ Past Abuse

How Much: \_\_\_\_\_\_\_\_\_ How Often: \_\_\_\_\_\_\_\_

***Use of Illicit Drugs:***

⬜ Never

⬜ Type and Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Pregnancies:***  ***Children:***

How Many: \_\_\_\_\_ How Many: \_\_\_\_\_

 ⬜ Natural ⬜ C-Section

**C. FAMILY MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease** | **Relative** | **Age** | **If Deceased, cause of death** |
|  |  |  |  |
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**D.** (Diabetics only) **When was your last hemoglobin A1C: \_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_%.**

**E.** **Have you ever had a Thyroid SCAN (not ultrasound):** ⬜ YES (If yes please bring in the actual films/cd) ⬜ NO

**Please check off any that may apply to you.**

|  |  |  |
| --- | --- | --- |
| **CARDIOVASCULAR** | **YES** | **NO** |
| Chest pain |  |  |
| Heart Attack |  |  |
| Heart trouble |  |  |
| Heart valve disease |  |  |
| High blood pressure |  |  |
| Palpitations |  |  |
| Rheumatic fever |  |  |
| Shortness of breath-lying |  |  |
| Shortness of breath-walking |  |  |
| Swelling of feet, ankles, or hands |  |  |

|  |  |  |
| --- | --- | --- |
| **EARS, NOSE, MOUTH, THROAT** | **YES** | **NO** |
| Bad breath/taste |  |  |
| Bleeding gums |  |  |
| Chronic sinus problems |  |  |
| Ear infections/drainage |  |  |
| Hearing loss or tingling |  |  |
| Hoarseness |  |  |
| Mouth sores |  |  |
| Nose bleeds |  |  |
| Swollen Glands in neck |  |  |

|  |  |  |
| --- | --- | --- |
| **ENDOCRINE** | **YES** | **NO** |
| Diabetes |  |  |
| Excessive thirst or urination |  |  |
| Glandular or hormone problem |  |  |
| Thyroid disease |  |  |

|  |  |  |
| --- | --- | --- |
| **EYES** | **YES** | **NO** |
| Blurred/double vision |  |  |
| Eye disease or injury |  |  |
| Eye infection |  |  |
| Glaucoma |  |  |

|  |  |  |
| --- | --- | --- |
| **GASTROINTESTINAL** | **YES** | **NO** |
| Abdominal pain |  |  |
| Blood in stool |  |  |
| Change in bowel movements |  |  |
| Cirrhosis |  |  |
| Constipation |  |  |
| Difficult or painful swallowing |  |  |
| Frequent diarrhea |  |  |
| Heartburn |  |  |
| Hemorrhoids |  |  |
| Hepatitis |  |  |
| Loss of appetite |  |  |
| Nausea or vomiting |  |  |
| Pancreatitis |  |  |
| Rectal bleeding |  |  |
| Yellow jaundice |  |  |

|  |  |  |
| --- | --- | --- |
| **GENERAL** | **YES** | **NO** |
| Fatigue/Malaise |  |  |
| More sensitive to hot/cold |  |  |
| Unexplained weight loss/gain |  |  |

|  |  |  |
| --- | --- | --- |
| **SKIN** | **YES** | **NO** |
| Change in hair or nails |  |  |
| Change in skin color |  |  |
| Hives |  |  |
| Rash or itching |  |  |

|  |  |  |
| --- | --- | --- |
| **GENITOURINARY** | **YES** | **NO** |
| Blood in urine |  |  |
| Burning or painful urination |  |  |
| Frequent urination |  |  |
| Kidney Stones |  |  |
| Menstrual problems |  |  |
| Prostate disease |  |  |
| Sexually transmitted disease |  |  |

|  |  |  |
| --- | --- | --- |
| **HEMATOLOGIC/LYMPHATIC** | **YES** | **NO** |
| Anemia |  |  |
| Bleeding or bruising easily |  |  |
| Cancer (area) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| HIV/AIDS |  |  |
| Leukemia |  |  |
| Lymphoma |  |  |
| Phlebitis/blood clots |  |  |
| Sickle cell |  |  |
| Slow to heal after cuts |  |  |

|  |  |  |
| --- | --- | --- |
| **MISCULOSKELETAL** | **YES** | **NO** |
| Arthritis |  |  |
| Back Pain |  |  |
| Difficulty in walking |  |  |
| Joint pain |  |  |
| Joint stiffness or swelling |  |  |
| Multiple sclerosis |  |  |
| Muscle pain or cramps |  |  |
| Muscular dystrophy |  |  |
| Weakness of muscles or joints |  |  |

|  |  |  |
| --- | --- | --- |
| **NEUROLOGICAL** | **YES** | **NO** |
| Convulsions or seizures |  |  |
| Frequent/recurring headaches |  |  |
| Head injury |  |  |
| Light-headed or dizzy |  |  |
| Migraines |  |  |
| Numbness or tingling sensation |  |  |
| Paralysis |  |  |
| Sleep apnea |  |  |

|  |  |  |
| --- | --- | --- |
| **PSYCHIATRIC** | **YES** | **NO** |
| Anxiety |  |  |
| Depression |  |  |
| Memory loss or confusion |  |  |
| Nervousness |  |  |
| Suicidal |  |  |

|  |  |  |
| --- | --- | --- |
| **RESPIRATORY** | **YES** | **NO** |
| Asthma or wheezing |  |  |
| Bronchitis |  |  |
| Chronic or frequent cough |  |  |
| Emphysema |  |  |
| Shortness of breath |  |  |
| Spitting up blood |  |  |
| Tuberculosis |  |  |

|  |  |  |
| --- | --- | --- |
| **VASCULAR** | **YES** | **NO** |
| Discoloration of extremities |  |  |
| Leg Pain |  |  |
| Leg swelling |  |  |
| Varicose veins |  |  |

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**MEDICARE QUESTIONAIRE AND AUTHORIZATION**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patients name as shown on Medicare Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Basis for Medicare: \_\_\_\_\_Age \_\_\_\_\_Disability \_\_\_\_\_Renal Disease

Do you have a secondary insurance: \_\_\_\_yes \_\_\_\_\_no

Name of Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you employed: \_\_\_\_\_yes \_\_\_\_\_no

If yes, Employers name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your spouse employed: \_\_\_\_yes \_\_\_\_no

Workers compensation: \_\_\_\_yes \_\_\_\_no

Veteran’s administration: \_\_\_\_yes \_\_\_\_no

Does the patient have a VA service card: \_\_\_\_yes \_\_\_\_no

Does the patient have benefits under the department of labor’s black lung program: \_\_\_\_yes \_\_\_\_no

Insurance other than Medicare is premium paid by

Employer (former): \_\_\_\_yes \_\_\_\_\_no or self: \_\_\_\_yes \_\_\_\_no

“I authorize any provider or Medicare or other information about me to release to the social security administration and health care financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request a payment of medical insurance either to myself or the party who accepts assignment.”

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TRI-COUNTY ENDOCRINOLOGY & NUCLEAR MEDICINE, P.C.**

**38731 MOUND RD, STE 200 STERLING HEIGHTS, MICHIGAN 48310 TEL. (586)939-8480 FAX (586)939-8487**

**NANCY J. ANDREWS. D.O., M.A.C.O.I., F.A.C.E. ERIC S. LANGER, D.O., F.A.C.O.I., F.A.C.E., C.C.D.**

 **AMY LUM TOBIN, D.O., F.A.C.O.I. Kelley Thomas, P.A.-C Brian Tsacoumangos, PA-C**

**Not required for all Patients, will be discussed at initial visit.**

**RMR**

Resting Metabolic Rate Testing

**Preparing for the test:**

It is desirable to measure your metabolic rate at a true resting level. Ensure you are at rest, we recommend the following preparation:

1. You should avoid eating 4 hours prior to testing. This does not include drinking, although very cold water can affect results.
2. Avoid exercising on the day or your test. This does not include normal activities.
3. If possible, avoid the use of stimulants, such as coffee, tea, and caffeinated pop. Over the counter antihistamines and herbal remedies should be avoided.

**During the breath test:**

During the test you will be invited to recline in a comfortable position. You will be given a mouthpiece to breathe into. You will be breathing in air from the room, but the gas that you breathe out will go into the metabolic analyzer to measure your metabolic rate.

1. Relax and close your eyes during the test. You deserve a break-enjoy it!
2. Keep lips sealed lightly around the mouthpiece. It is important that all the air you breathe is analyzed.
3. In just 10 minutes, your metabolic rate will be measured, and those results will be used to calculate your target caloric zones. These zones will be printed out in an easy to understand format that you, your physician and dietitian will interpret.

**If you have any questions please call our office at 586-939-8480**

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**Required for all Diabetic Patients, will be discussed at initial visit.**

**CGMS**

**(Continuous Glucose Monitoring System)**

The Continuous Glucose Monitor is not implanted! A tiny glucose sensor at the end of the recorder will be inserted under the skin in a virtually painless process. Once it is inserted you will continue your daily routine as usual. Adverse reactions associated with glucose sensor insertion are highly uncommon and are limited to bleeding, irritation, pain, rash, infection, raised bump, and irritation at the site from the tape or bandage to secure the CGM to the skin.

Glucose measurements are automatically collected and stored in the recorder. A total of 288 glucose reading-every 5 minutes throughout the day are recorded. Once your testing is complete, personalized reports will be generated allowing you and your doctor to fine tune your diabetes therapy. Remember, it does not display glucose values and is not intended to replace home glucose monitoring.

* Take blood glucose readings 4 times a day for the next 3-5 days.
* Record these and daily events such as meals, insulin, (if you take) and exercise in the Patient logbook you are given.
	+ - * Test with your BG meter 2 hours after the start of you CGM evaluation (and not before 2 hours) and record the exact time in your logbook.
			* Test 4 times a day using your BG meter before breakfast, lunch, dinner, and before bed and record the exact time in your logbook.
* Protect the CGM Recorder and glucose sensor site form accidental removal and refrain from contact sports or activities which may damage the monitor.
* If you are to have an X-ray, CT or MRI, the iPro needs to be removed prior to doing so.
* The CGMS is waterproof, but should not be worn swimming for longer than 30 minutes at a depth of 8 feet. Hot baths should be avoided for longer than 10 minutes.
* Avoid wearing or being around magnets while wearing the CGMS (examples: cell phone holder, bracelet, belt, magnetic mattress pad).
* Do not administer insulin within 3 inches of the glucose sensor site.
* If tape peels back/becomes loose, do not remove or you could pull the sensor out! Place another piece of tape or band aid on top to secure.

**COME BACK TO YOUR DOCTORS OFFICE FOR REMOVAL WHEN INITIATED TO**