Lovelace
Medical Group

Scheduling a Consultation with a Lovelace Endocrinologist

In an effort to optimize our ability to serve as many patients as possible, our clinic must receive complete medical records related to your endocrinology issue prior to scheduling your first appointment. We thank you in advance for your cooperation. We can receive these documents by mail or fax at the address and fax number printed below.

After receiving and reviewing your records, we will contact you to schedule your appointment. If you have not heard form us within 7-10 business days of the submission of your medical information, please call us at 505-727-6200.

Many of our patients simply give a copy of this instruction sheet to their referring providers to facilitate the process of submitting their records.

Here is the checklist of documents needed to schedule your appointment:

☐ LMG Endocrinology New Patient Questionnaire packet (to be completed and submitted by the patient)
☐ Referral request from your referring physician or provider
☐ Last 2 notes from your endocrinologist, if you are transferring care
☐ Lab reports from the past 6 months pertaining to your endocrine condition
☐ Lab report from the time of initial diagnosis, if more than 6 months ago
☐ Pathology/Biopsy reports relating to your endocrine issue, if applicable
☐ Operative notes relating to your endocrine issue, if applicable
☐ Hospital or emergency records relating to your endocrine issue in past year

☐ Imaging reports (CT, DXA, MRI, nuclear, ultrasound) pertaining to your endocrine condition, if applicable.

PLEASE SUBMIT THE ABOVE INFORMATION BY MAIL OR FAX TO:

Lovelace Medical Group, Division of Endocrinology
Attention: Endocrinology
6701 Jefferson St NE, Albuquerque, NM 87109
Phone:505-727-6200 FAX: 505-727-7069

Lovelace
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Endocrinology Diabetes and Metabolism
New Patient Questionnaire

Legal Name: Last	First:	Middle:	☐ Female ☐ Male
Primary Phone:	Secondary Phone:	Date of Birth:	
	Primary Care Provider:	Referring Provider:	

Referring Doctor

Provider Name:	Address:	Phone Number:

Reason for visit:

- ☐ Adrenal Issues
- ☐ Body weight problem
- ☐ Calcium Problem
- ☐ Cholesterol Problem
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diabetes in Pregnancy
- ☐ History of bariatric surgery
- ☐ Hypertension
- ☐ Hyperthyroidism (high)
- ☐ Hypothyroidism (low)
- ☐ Menopausal problem
- ☐ Osteoporosis
- ☐ Pitutary tumor
- ☐ Polycystic Ovaries
- ☐ Prediabetes / Diabetes Prevention
- ☐ Premature ovary insufficiency
- ☐ Testosterone problem
- ☐ Thyroid Cancer
- ☐ Transgender care
- ☐ Other

Medications *(List all current medications)*

☐ No Current Medications

Medication Name	Dosage Strength (i.e.,mg/mcg)	How many times a day?
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Allergies

☐ Check box if ther are NO medication allergies.

Drug Name/ Drug Class/ Food	Reaction
1	
2	
3	

Review of Systems

Check all that apply to current issues/symptoms

General Well-Being
- ☐ Decreased Appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Increased Appetite
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Blood System
- ☐ Bleed Easily
- ☐ Bruise Easily
- ☐ Enlarged Lymph Nodes
- ☐ Clots

Gastrointestional
- ☐ Bloating/ Gas
- ☐ Reflux
- ☐ Blood in stools
- ☐ Nausea/ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn

Cardiovascular
- ☐ Chest Pain
- ☐ Swelling of ankles
- ☐ Trouble breathing at night
- ☐ Trouble sleeping w/out elevating head
- ☐ Fast or irregular heartbeat

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Painful Breathing
- ☐ Wheezing

Endocrine
- ☐ Chronically Overweight
- ☐ Chronically Underweight
- ☐ Cold Intolerance
- ☐ Enlarged thyroid
- ☐ Heat intolerance
- ☐ Increased thirst
- ☐ Tremors of hands

Reproductive
- ☐ Breast Discharge
- ☐ Painful intercourse
- ☐ Erectile dysfunction (male)
- ☐ Irregular periods (female)

Throat
- ☐ Voice Change
- ☐ Problems Swallowing
- ☐ Hoarseness
- ☐ Lump in throat
- ☐ Sore Throat
- ☐ Snoring

Neurological
- ☐ Dizziness
- ☐ Difficulty Walking
- ☐ Headache
- ☐ Memory Problems
- ☐ Tingling or pins/needles feeling
- ☐ Seizures
- ☐ Visual Changes

Urinary
- ☐ Decreased stream
- ☐ Decreased urine output
- ☐ Painful Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urinary urge

Eyes
- ☐ Double vision
- ☐ Sensitivity to sun
- ☐ Redness
- ☐ Eye Pain
- ☐ Loss of vision

Musculosketal
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle weakness

Skin
- ☐ Acne
- ☐ Hair loss
- ☐ Hair Growth
- ☐ Rash
- ☐ Pigment change

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty concentrating

Past Medical History

Check all that apply.

Cardiac
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Irregular heartbeat
- ☐ Mitral valve prolapse
- ☐ Peripheral vascular disease
- ☐ Stroke

Respiratory
- ☐ Asthma
- ☐ Cronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pulmonary embolism

Musculoskeletal
- ☐ Arthritis
- ☐ Other_____

Gastrointestinal
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Constipation
- ☐ Diverticulitis
- ☐ Crohns/ colitis

Hematologic
- ☐ Easy bleeding/ brusing
- ☐ Hx of blood clot

Genitourinary/ Repoductive
- ☐ Many urine infections
- ☐ Kidney Stones
- ☐ Infertility
- ☐ Erectile dysfunction (male)
- ☐ Gestational diabetes (female)
- ☐ Irregular periods

Cancer Type:_____

_____

Date Diagnosed:_____

Females
- ☐ Polycystic Ovary Syndrome
- ☐ Unwanted facial or body hair

Neurologic
- ☐ Spine /back injury
- ☐ Seizure disorder
- ☐ Migraines
- ☐ Recurrent headaches

Endocrine
- ☐ Diabetes
- ☐ Low Thyroid
- ☐ High Thyroid
- ☐ Osteoporosis
- ☐ High Cholesterol
- ☐ Steroid use
- ☐ Excessive weight gain

Past Surgical History

Please list the surgeries you have had, date and location. ☐ None

Surgery	Date	Location

Family History

Are you adopted? ☐ Yes ☐ No *If yes, complete for any known biological relative.*

Diagnosis	Circle one	Family Member	Diagnosis	Circle one	Family Member
Adrenal disease	No Yes		Heart attack	No Yes	
Alzheimer's disease	No Yes		Hyperlipidemia	No Yes	
Asthma	No Yes		Obesity	No Yes	
Blood disorders	No Yes		Osteoporosis	No Yes	
Cancer (type):	No Yes		Parathyroid disease	No Yes	
Cardiac disease	No Yes		Thyroid disease	No Yes	
Colon cancer	No Yes		Stroke	No Yes	
Congestive Heart Failure	No Yes		Seizure disorder	No Yes	
Diabetes type 1	No Yes		Ulcerative colitis	No Yes	
Diabetes type 2	No Yes		Other:	No Yes	
Diverticular disease	No Yes		Other:	No Yes	

Social History

Your answers may help determine your risk for certain diseases. Responses are confidential.

Tobacco Use

Do you… ☐ Smoke a pipe ☐ Chew Tobacco ☐ Smoke Cigarettes

How many…

Packs per day? _____

Years? _____

If you quit, what year? _____

Do you exercise? ☐ Yes ☐ No

If yes,:

Aerobic activity? ☐ Yes ☐ No times per week?:_____

Strength training? ☐ Yes ☐ No times per week?:_____

Yoga/ stretching? ☐ Yes ☐ No times per week?:_____

Are you currently pregnant: ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes

If yes, what type? _____

If yes, how much? _____

If yes, how often? ☐ Daily ☐ Monthly ☐ Weekly ☐ Occasionally ☐ Rarely

Do you use recreational drugs? ☐ Yes ☐ No

If yes, what type? _____

_____

Is there anything specific you wish to discuss with the physician this visit?

_____

_____

_____

_____

_____

If you have *diabetes* , complete the following questions:

At what age was your diabetes diagnosed? _____

Have you seen a diabetes educatior? ☐ Yes ☐ No

Have you seen a nutritionst regarding your diabetes? ☐ Yes ☐ No

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Diabetes in pregnacy ☐ Do not know

Do you check your blood sugars at home? ☐ Yes ☐ No

If yes, what is a high reading for you? _____

What is a low reading for you?_____

How many times per day do you check your sugars? _____

Do your sugars ever go below 70? ☐ Yes ☐ No

If yes, is this ☐ daily ☐ weekly ☐ monthly ☐ rarely

Are you aware of when your sugars go low? ☐ Yes ☐ No

Have you ever been hospitalized for high blood sugars? ☐ Yes ☐ No

If yes, when_____ and where_____

Have you had a pneumonia vaccination? ☐ Yes ☐ No

Do you know your HgA1c? ☐ Yes ☐ No

Last HgA1c_____ Date:_____

Have you ever been hospitalized for low blood sugars? ☐ Yes ☐ No

If yes, when_____ and where_____

Do you have diabetes related eye problems? ☐ Yes ☐ No Eye Doctor:_____

When was your last eye exam?_____ ☐ Never

Do you have foot problems? ☐ Yes ☐ No Foot Doctor:_____

When did you last give a urine sample for you diabetes? _____ ☐ Never

Do you have diabetes related kidney problems? ☐ Yes ☐ No ☐ Dont know

When did you last have a cardiac assessment? Date:_____ ☐ Never

Do you have heart disease? ☐ Yes ☐ No

Males: Do you have erectile dysfunction? ☐ Yes ☐ No

Do you have any specific issues you would like to address with your physician regarding your diabetes?

_____

_____

_____

What obstacles are you running into with diabetes management?

_____

_____

_____

If you are being seen for *thyroid cancer* , complete the following questions:

At what age was your thyroid cancer diagnosed?_____

Did you have surgery for your thyroid cancer? ☐ Yes ☐ No

If yes, when_____ and where_____

Did you have radioactive iodine? ☐ Yes ☐ No

If yes, do you recall what dose? Dose:_____

What is your current dose of thyriod hormone? Dose:_____

Do you have a history of low calcium? ☐ Yes ☐ No

If yes, what medication are you taking for it? Medication:_____

When was your last neck ultrasound performed? ☐ Not applicable

Date:_____ Location:_____

Do you know your most recent TSH and thyroglobulin level?

TSH:_____ Thyroglobulin level:_____

If you are being seen for *osteoporosis,* complete the following questions:

Have you ever been treated for osteoporosis? ☐ Yes ☐ No

If yes, with what medications_____ From what dates _____ to _____

Is there a family history of osteoporosis and/or hip fracture? ☐ Yes ☐ No

If yes, list family member _____

Do you have a history of hip or spine fracture?

If yes, list location _____ age_____

Do you have a history of any other bone fractures? ☐ Yes ☐ No

If yes, list location _____ age_____

Are you lactose-intolerant? ☐ Yes ☐ No

Have you ever been diagnosed with thyroid disorder? ☐ Yes ☐ No

Have you ever been diagnosed with calcium disorder? ☐ Yes ☐ No

Do you have a history of kidney stones? ☐ Yes ☐ No

Do you have a history of anorexia? ☐ Yes ☐ No

When was your last bone density test? Date:_____ Location:_____ ☐ N/A

Do you take calcium or vitimin D? ☐ Yes ☐ No

If yes, Calcium dose:_____ Vitamin D dose:_____

Females: are you in menopause? ☐ Yes ☐ No

If yes, were you treated with Hormone replacement therapy? ☐ Yes ☐ No

Indicate from what dates- from_____ to _____