SHORE PHYSICIANS GROUP℠

DIVISION *of* ENDOCRINOLOGY

Welcome to Shore Physicians Group Endocrinology and the practices of Dr. Vijay babu Balakrishnan, Dr. Matthew Corcoran, and Denyse Gallagher, APN.

Thank you for choosing us for your diabetes and endocrinology care. The enclosed packet contains important forms for completion prior to your visit - demographic information, a health questionnaire and a medical records release form. Please complete and return all forms to the office within 7 days. In order for us to deliver the best medical care possible, it is important that we have these forms and your medical records at the time of your visit. The team will also need your most recent and relevant laboratory results and imaging studies (CT scan, MRI, Ultrasound and Biopsy Reports and Pathology). If it is not possible to deliver all of this information within 3 business days of your appointment, please bring them on the day of your visit. Otherwise, it may be necessary to reschedule the appointment.

If you need a referral to see a specialist based on your health insurance carrier, please obtain this prior to your office visit. If you do not have the proper insurance referral that your health insurance requires, your appointment will need to be rescheduled.

Patients with diabetes are requested to bring a report or log of their most recent blood sugar readings for the last two weeks. We have enclosed a blood glucose (sugar) log for you. If utilize technologies, including insulin pumps and/or continuous glucose monitoring devices, please include the type of device you are using on the attached forms.

If you have diabetic supplies that need to be ordered or renewed through a mail-order pharmacy per your insurance guidelines, please bring this information with you.

Also, please bring a list of your current medications, dosages, and how you take them to your appointment. If you are requesting a refill of any medication, please bring that information with you as well.

Our cancellation/late policy is: If a cancellation is not made 24 hours prior to the scheduled appointment, you will be charged a No Show fee ($25). If you arrive more than 15 minutes late, your appointment may need to be rescheduled.

Communication with our office and/or the health care provider- please consider using our portal system. We have included instructions for using the portal with this letter, and/or our team can help you with the instructions on signing on to the portal on the day of your appointment.

We offer a unique chronic care management program for our patients with diabetes to help you achieve your health and wellness goals. Please speak with your provider at time of your visit for more information.

If you have any questions or concerns that we can assist you with, please do not hesitate to contact us at the Northfield office (609) 365-5300 or Mays Landing at (609) 365-6217 or email us at Endo@shorephysiciansgroup.com.

We look forward to seeing you and thank you for choosing Shore Physicians Group Endocrinology.

Patient Name: _____ DOB: _____ Date: _____

Email: _____ Insulin Pump: _____

Continuous Glucose Monitor: _____ Do you use □ receiver/ □ meter/ or □ phone?

Primary Physician: _____ Other Physicians: _____

Pharmacy Name/Address/Phone Number: _____

Preferred Lab: _____ Preferred Radiology Facility: _____

Reason for Visit: _____ Occupation: _____

Allergies: Please list all Drug/Food/Latex Allergies

Allergy	Reaction

Medication History: Please list all Current Medication you are taking (Med List Attached -- ❑Yes ❑No)

Medication	Dosage	How Taken

Vaccinations: Are you current with your vaccinations? ❑Yes ❑No

Date of Last Tetanus Shot _____ Date of Last Flu Shot _____

Family History: List Current or Past Medical Conditions of Mother/Father/Brother/Sister/Grandparents/Aunts/Uncles
Unknown Family History ❑Yes ❑No

Medical Condition	Relative	Relative	Age of Onset	If Deceased Age and Cause of Death
Diabetes	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Heart Disease	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Thyroid Disease	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Hypertension	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Hip Fracture	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Osteoporosis	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Cholesterol Disorder	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			
Others	❑ M ❑ F ❑ B ❑ S ❑ GM ❑ GF ❑ A ❑ U			

Social History: Please put an "X" in the appropriate boxes, or complete as applicable:
Do you drink Alcoholic Beverages? ❑Never ❑ Rarely ❑ Moderately ❑Frequently
How many days in the past year have you had 4 or more alcoholic beverages on the same day? _____
Do you use Tobacco? ❑ Never ❑Former ❑Current Daily ❑Current Occasionally ❑Unknown
How much do you Smoke? ❑1PPW ❑2PPW ❑ ¼ PPD ❑ ½ PPD ❑1PPD ❑1 1/2 PPD ❑2PPD ❑3+PPD
Do you use the E-Cigarette? ❑ Yes ❑ No Are you routinely exposed to "Second Hand Smoke"? ❑Yes ❑No
Do you currently or have you ever used illegal or illicit drugs ❑Yes ❑No --- if Yes What? _____
Are you Sexually Active? ❑Yes ❑No Do you have protected sex? ❑ Yes ❑ No
Do you have any Religious or Cultural Customs that the physician should be aware of? ❑Yes_____ ❑No

Do you have an Advanced Directive or Living Will: ❑Yes ❑ No

Surgical History: Please list any surgery that you have had as well as date if possible

Surgical Procedure	Yes or No	Date	Performed By
Thyroid Surgery	❑Yes ❑No		
Parathyroid Surgery	❑Yes ❑No		
Heart Surgery	❑Yes ❑No		
Gastric Bypass or Other Bariatric	❑Yes ❑No		
Organ Transplant	❑Yes ❑No		
Foot Surgery	❑Yes ❑No		
Colonoscopy	❑Yes ❑No		

GYN History: Women Only

Any Chance of Current Pregnancy? ❑Yes ❑ No Date of Last Period? _____ Age of first period? _____

Number of Days between Cycles? _____ Are you using Oral Contraceptives? ❑Yes ❑No

Date of Last Pap? _____ Date of Last Mammogram? _____

Date of Last Bone Density Study? _____ Are you Post-Menopausal? _____

OB History:

Total Number of Pregnancies? _____ Full Term_____ Premature_____ Abortions Induced_____

Abortions Spontaneous_____ Ectopic _____ Multiple _____ Living _____

PAST MEDICAL History:

❑ Y	❑ N	Amputations	❑ Y	❑ N	Heart Failure	Other Not Listed
❑ Y	❑ N	Anxiety	❑ Y	❑ N	Hypertension	
❑ Y	❑ N	Arthritis	❑ Y	❑ N	Hypogonadism	
❑ Y	❑ N	Asthma	❑ Y	❑ N	Kidney Disease	
❑ Y	❑ N	Atrial Fibrillation/Arrhythmia	❑ Y	❑ N	Kidney Stones	
❑ Y	❑ N	Benign Tumors/Nodules	❑ Y	❑ N	Obesity	
❑ Y	❑ N	COPD	❑ Y	❑ N	Obstructive Sleep apnea	
❑ Y	❑ N	Cancer	❑ Y	❑ N	Osteoporosis	
❑ Y	❑ N	Cholesterol Disorder	❑ Y	❑ N	Peptic Ulcer/Reflux Esophagitis	
❑ Y	❑ N	Coronary Artery Disease	❑ Y	❑ N	Polycystic Ovarian Disease	
❑ Y	❑ N	Depression	❑ Y	❑ N	Seizures	
❑ Y	❑ N	Diabetes	❑ Y	❑ N	Stroke	
❑ Y	❑ N	Fractures	❑ Y	❑ N	Testosterone Issues	
❑ Y	❑ N	Heart Conditions	❑ Y	❑ N	Thyroid Disease	
			❑ Y	❑ N	Vitamin D Deficiency	

Review of Systems: Please check Yes or No

Constitutional

Fever	❑Yes ❑No			
Fatigue	❑Yes ❑No			
Weight Gain	❑Yes ❑No			
Weight Loss	❑Yes ❑No			
Difficulty Sleeping	❑Yes ❑No			

Eyes

Change in Vision	❑Yes ❑No			
Double Vision	❑Yes ❑No			
Redness in Eyes	❑Yes ❑No			
Eye Pain	❑Yes ❑No			

ENT

Difficulty Swallowing	❑Yes ❑No			
Change in Voice	❑Yes ❑No			
Swelling in Neck	❑Yes ❑No			
Sore Throat	❑Yes ❑No			
Neck Pain	❑Yes ❑No			

Endocrine

Hair Loss	❑Yes ❑No			
Intolerance to Heat	❑Yes ❑No			
Intolerance to Cold	❑Yes ❑No			
Excessive Sweating	❑Yes ❑No			
Tremor	❑Yes ❑No			
Excessive Urination	❑Yes ❑No			
Excessive Thirst	❑Yes ❑No			

Cardiovascular

Chest Pain	❑Yes ❑No			
Palpitations	❑Yes ❑No			
Swelling of Extremities	❑Yes ❑No			

Respiratory

Cough	❑Yes ❑No			
Shortness of Breath	❑Yes ❑No			

Gastrointestinal

Nausea	❑Yes ❑No			
Vomiting	❑Yes ❑No			
Abdominal Pain	❑Yes ❑No			
Diarrhea	❑Yes ❑No			
Constipation	❑Yes ❑No			

Skin

Rash	❑Yes ❑No			
Ulcers or Wounds	❑Yes ❑No			

Neurological

Headache	❑Yes ❑No			
Weakness	❑Yes ❑No			
Numbness or Change in Sensation	❑Yes ❑No			

Psychiatric

Depression	❑Yes ❑No			
Anxiety	❑Yes ❑No			

Podiatric

Have you had a diabetic Foot Exam?	❑Yes ❑No			
Podiatrist Name: _____	Date of Exam: _____			

Eye

Have you had a Dilated Eye Exam in last 12 months?	❑Yes ❑No			
Ophthalmologist/Optometrist Name: _____	Date of Exam: _____			

Name of Person Completing Form: _____

Signature: _____ **Relationship to Patient:** _____

Meal Log for the Week of _____.

	Breakfast	Lunch	Dinner	Snacks
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Blood Glucose Log for the Week of _____.

	Breakfast			Lunch			Dinner			Bedtime		Night	Comments
	Blood Sugar Before	Insulin Units/ Type	Blood Sugar After	Blood Sugar Before	Insulin Units/ Type	Blood Sugar After	Blood Sugar Before	Insulin Units/ Type	Blood Sugar After	Blood Sugar Before	Insulin Units/ Type	Blood Sugar	
Mon.													
Tues.													
Wed.													
Thurs.													
Fri.													
Sat.													
Sun.													