UAB MEDICINE
MULTISPECIALTY CLINIC
BAPTIST MEDICAL CENTER SOUTH

2119 East South Boulevard
Montgomery, AL 36116
(334) 747-7070

Endocrinology
2119 East South Blvd.
1st Floor
Montgomery, AL 36116
Phone: 334-747-7070

New Patient Appointment - Endocrinology

____, you have an appointment with

☐ **Dr. Manisha Garg** ☐ **Dr. Vaishala Thudi** ☐ **Dr. Akinola Ayodeji** ☐ **Dr. Ahsan Farooq**

on

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

_________________ at_________________A.M. P.M.

Please bring all of your medications with you to your appointment.

If you are diabetic, please bring your meter with you to your appointment.

You **must** arrive 30 minutes prior to your appointment **with your paperwork completed.**

If you are not able to make this appointment, please call 334-747-7070 as soon as possible. You **must** arrive 30 minutes prior to your appointment to ensure we are able to see you. Please know your appointment may be rescheduled if you do not arrive on time. On the day of your appointment, please bring the following items with you:

- **Enclosed Paperwork – Please complete all of the enclosed paperwork prior to arriving for your appointment.**
- **Photo identification card.**
- **Co-pay**
- **Insurance Card.**
- **Medication bottles: Please bring the actual bottles for all medications you are currently taking.**

All co-pays are due prior to services rendered

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NEW PATIENT INFORMATION FORM

Helpful Information & Directions

The UAB Multispecialty Clinic is located on the campus of Baptist Medical Center South. The UAB building is a three-story building located on the right (east) side of the campus, across from the Emergency Room ambulance bays.

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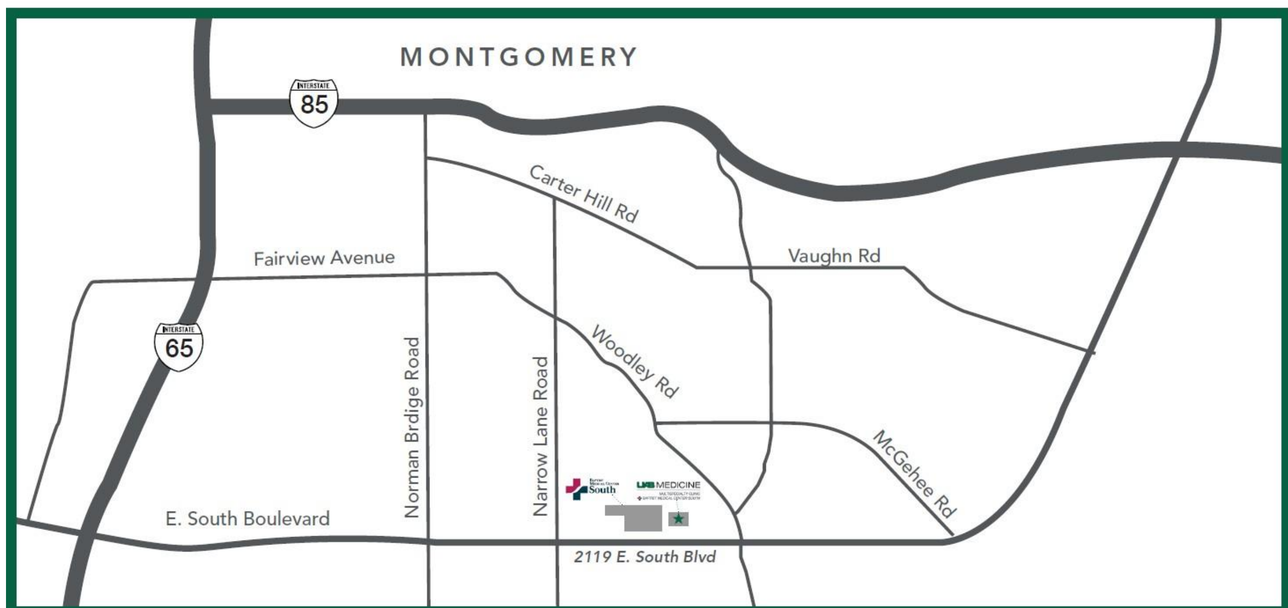

When you come for your appointment:

- Bring all of your medication in their original containers.
- Bring your insurance card and driver’s license or other photo identification.
- **You must arrive 30 minutes before your appointment time <u>with your new patient paperwork completed.</u>**

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Endocrinology Patient Intake Form

Patient Name____________________________Date of Birth________________Today's Date ______________

Reason for Visit

____

Referring Physician_____________________________Phone______________________Fax ________________

Past Endocrinologist____Phone__________________________

Past Medical History – Please Check All That Apply.

☐ Diabetes Type I	☐ CHF	☐ Seasonal Allergies
☐ Diabetes Type II	☐ COPD	☐ Seizure Disorder
☐ High Cholesterol	☐ High Blood Pressure	☐ Stoke
☐ TIA	☐ Hyperthyroidism	☐ Cushing's Disease
☐ Acromegaly	☐ Hypothyroidism	☐ Hyper/Hypoparathyroidism
☐ Hyperparathyroidism	☐ Cancer – Breast	☐ Kidney Stone
☐ Pituitary tumors	☐ Cancer – Cervical	☐ Adrenal Nodule
☐ Thyroid Nodule	☐ Cancer – Colon	☐ Nephropathy
☐ Retinopathy	☐ Cancer – Prostate	☐ Neuropathy
☐ Anxiety	☐ Depression	☐ Osteoarthritis
☐ Anemia	☐ Asthma	☐ GERD/Acid Reflux
☐ Osteopenia	☐ Osteoporosis	☐ Cirrhosis

Allergies: Pleas List Any Medication, Foods, or Chemicals That May Cause Allergic Reaction.

ITEM	REACTION	ITEM	REACTION

Medications – Please Include All Prescription and Non-Prescription (Over the Counter) Drugs You Take Regularly

Drug	Dose + How Often	Drug	Dose + How Often

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Family History – Please Check All That Apply

	Mother	Father	Brother	Sister	Grandmother	Grandfather	Child(ren)
Allergies							
Anemia							
Aneurysm							
Anxiety							
Asthma							
Cancer							
CHF							
Clots							
COPD							
Depression							
Diabetes							
Emphysema							
Headache							
Heart Attack							
High Blood Pressure							
High Cholesterol							
Hypothyroid							
Hyperthyroid							
Kidney Stone							
Migraine							
Osteoporosis							
Prostate Issues							
Sleep Apnea							
Sickle Cell							
Stroke							
Other							

Surgeries – Please List Any Surgical Procedures (Inpatient or Outpatient)

Date	Type of Surgery	Date	Type of Surgery

Social History – Please Indicate How Much Per Day and/or How Long

Alcohol Use	
Tobacco/Chewing or Smoking	
Caffeine	
Recreational Drug Use	

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DIABETES INTAKE FORM

Duration of Diabetes

How was it diagnosed?

Prior treatment:

CURRENT treatment for Diabetes with dosage:

How often do you check blood glucose? **Name of Meter:**______________________________

Fasting/morning:
Pre-lunch:
Pre-supper:
Bedtime:
Any low blood glucose:
Have you ever been hospitalized for your Diabetes?

Diet/Exercise:

How many meals do you eat per day?
Do you eat a snack? yes /no
Juice /Sodas? yes/no
Do you exercise? yes/no If so, How many times weekly and what type:_____________________
____

Diabetes Complications assessment:

Do you have Diabetic retinopathy/Diabetes eye disease? yes/no
When was your last eye exam? Date:______________
Do you see a foot doctor? yes/no If so, Date:__________________
Do you have neuropathy/ nerve damage from Diabetes? yes/no
Do you have kidney disease? yes/no
Any heart condition? yes/no
Have you had a stroke or TIA? yes/no If so, Date:__________________
Do you have high blood pressure? yes/no

Previous fracture?
____

Date of last bone density? _______________________________

Where? ________________________________