METABOLIC MEDICINE OF MISSISSIPPI

DIABETES AND ENDOCRINE SPECIALISTS

Dr. Honey E. East FACP

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Date: _____

Please completely fill out the following.

Name: _____ **DOB:** _____ **SSN:** _____

Address: _____ **City/ST:** _____ **Zip Code** _____

Cell: _____ **Home:** _____ **Work:** _____

Email: _____ **Best time to contact:** _____

Primary Insurance: _____ **Policy #:** _____ **Group #:** _____

Insured Name: _____ **Insured date of birth:** _____ **SSN:** _____

Patients relationship to insured: SELF SPOUSE CHILD OTHER

Secondary Insurance: _____ **Policy#:** _____ **Group#:** _____

Insured Name: _____ **Insured date of birth:** _____ **SSN:** _____

Patients relationship to insured: SELF SPOUSE CHILD OTHER

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

Primary Care Provider: _____ **Preferred Pharmacy and location:** _____

List of current medications:

List any allergies:

List of surgeries/hospitalizations:

List any past family medical history:

REVIEW OF SYSTEMS: Please CIRCLE ALL that apply to you. Failure to answer may affect your medical care.

Name: _____ **Sex:** _____ **DOB:** _____ **Date:** _____

GENERAL:

Weight: Stable Gain/Loss _____ pounds over _____ months

Energy levels:

Low Stable Increased

EYES:

Seeing Double Red eyes
Change in vision
Change in ability to see out of side of eyes (peripheral vision)

EARS/NOSE/MOUTH/THROAT:

Nosebleeds Runny nose Sore throat
New spacing of teeth
Dry mouth Mouth Ulcers Change in voice

NECK:

Change in appearance
Soreness on front of neck
Trouble swallowing
Sensation something stuck in throat

HEART:

Chest pain Heart racing

LUNGS:

Trouble breathing at rest Trouble breathing with activity
Trouble breathing when trying to sleep
Wheezing Cough Snoring
Sleep apnea- Wearing CPAP? Yes No
Recent Sleep study? Yes No

GASTROINTESTINAL:

Nausea Vomiting Constipation Diarrhea
Abdominal pain Pancreas problems

MUSCULOSKELETAL:

Joint pain Muscle pain Weakness
Change in shoe size Change in ring size
Broken bone or fracture Bone Density test

NEUROLOGICAL:

Tremors Seizures Headaches

ENDOCRINE:

Heat intolerance/hot flashes
Cold intolerance/chills increased thirst
Breast enlargement Breast leakage
History of kidney stones UTIs
Frequent urination Yeast infections

SKIN:

Rashes New stretch marks Do you bruise easily?

PSYCHIATRIC:

Trouble with memory Trouble with concentration
Mood Swings Sadness Anxiety
Falling asleep at inappropriate times

MEDICATIONS:

Recent injections (Decadron, joint, spine, etc...) Steroid creams, inhaler, nose spray
Over the counter cold medication
Over the counter vitamin supplements

For FEMALES ONLY:

Age of first menstruation (cycle):____
Last Cycle: _____ Irregular cycle: Yes NO
Difficulty getting pregnant: Yes No
Increased hair growth on face/chest: Yes No
Miscarriage: Yes No
Children weighting over 8lbs at birth? Yes No
History of PCOS? Yes No

For MALES ONLY:

Age of puberty: ____
Change in hair growth/frequency in need to shave: Yes NO
Increase/Decrease in sexual desire: Yes No
Erectile dysfunction: Yes No
Changes in testicles (growth or shrinkage): Yes No
History of testicular infection: Yes No
Biological Children? Yes No

Complete this page if you have diabetes.

Name: _____ **Sex:** _____ **DOB:** _____ **Date:** _____

What year were you diagnosed with diabetes? (ok to approximate) _____

How many times a day do you check your sugars? 1x 2x 3x 4x 5x+

Do you keep a blood sugar log? Yes No

What are your glucose readings when you wake up before you eat?

Lowest_____

Usual_____

Highest_____

What is your glucose?

After breakfast_____

Before Lunch _____

After Lunch _____

Before evening meal_____

After Evening meal/before bed _____

Have you ever been in the hospital just for your diabetes? Yes No

Have you ever been in a diabetic coma or DKA? Yes No

What is the lowest glucose reading you have ever had? _____

Have you ever passed out from a low blood sugar? Yes No

What is the name of your glucose meter? _____

Who is your eye doctor? _____ When was your last visit with them? _____

Do you have changes in your eye from your diabetes or had laser eye surgery? Yes No

Do you see a podiatrist (foot doctor) Yes No

Their name _____ last appointment date_____

Have you of anyone in your family ever had pancreatitis, pancreatic cancer or other pancreatic problems? Yes No

List any diabetic medication that you are allergic to or not able to tolerate:

Directions to 1551 E. County Line Road, Jackson, MS 39211

Traveling I-55 South:

Take exit 103 County Line Road/Ridgeland

Use 2 left lanes to turn left onto County Line Road.

Continue down County Line Road est 1.3 miles.

Metabolic Medicine on the right.

Traveling I-55 North:

Take exit 103 County Line Road/Ridgeland

Use Right Lane to merge onto County Line Road.

Continue down County Line Road est 1.2 miles.

Metabolic Medicine on the right.