

West Coast Endocrine, Inc.

Jennifer L. Hsieh, D.O., F.A.C.E.

Board Certified Endocrinology, Diabetes, and Metabolism
2865 Atlantic Ave. Suite 211, Long Beach CA 90806

ph (562) 988-0040 fax (562) 988-0041

New Patient Questionnaire:

Medical problems?

- | | |
|--|---|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> depression |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> foot ulcers |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> eye disorders, ie. Cataract, glaucoma, etc |
| <input type="checkbox"/> thyroid disorder | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> other | |

Previous surgeries?

Do you smoke? If yes, how many packs per day?

Do you drink alcohol? If yes, how much?

Family medical history

- | | | |
|--|-----------------------------------|---|
| <input type="checkbox"/> heart disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> thyroid disorder |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> strokes | <input type="checkbox"/> cancer |
| <input type="checkbox"/> depression | <input type="checkbox"/> other | |

Allergies?

Medications (Please list all prescription and non-prescription meds)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Current problems:

- | | |
|--|--|
| <input type="checkbox"/> visual disturbance | <input type="checkbox"/> frequent urination |
| <input type="checkbox"/> headaches | <input type="checkbox"/> frequent thirst |
| <input type="checkbox"/> trouble swallowing | <input type="checkbox"/> tingling/numbness |
| <input type="checkbox"/> choking sensation | <input type="checkbox"/> heart palpitations |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> tremors |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heat intolerance |
| <input type="checkbox"/> cough | <input type="checkbox"/> cold intolerance |
| <input type="checkbox"/> heartburn | <input type="checkbox"/> extreme fatigue |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> unexplained weight gain |
| <input type="checkbox"/> constipation | <input type="checkbox"/> unexplained weight loss |

Women only:

- Last menstrual period
- Cycle of period, every ___ days
- Any pregnancies?
- Abnormal hair growth
- History of gestational diabetes

Men only:

- Is sex drive normal?
- Erectile dysfunction

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New Patient Information

Patient name: _____ D.O.B.: _____ Social Security #: _____

Home address: _____

Home phone#: _____ Work phone #: _____ Mobile #: _____

E-mail address: _____

Marital Status: Married Single Divorced Widowed

Name of Spouse or next of kin: _____

Occupation: _____

Name of Employer: _____

Address of Employer: _____

Emergency contact: _____ Phone #: _____

Primary Care Doctor: _____

Where you referred? Yes or NO

If yes, by whom? _____

Insurance info:

Primary Carrier

Insurance carrier: _____ Policy # _____

Secondary Carrier

Insurance carrier: _____ Policy # _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to West Coast Endocrine, Inc. for all services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Your signature _____