

**Chris K. Guerin, M.D., F.A.C.E.**  
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**Tri-City Endocrinology and Metabolism**  
**3927 Waring Road, Suite C**  
**Oceanside, CA 92056**  
**(760) 941-9850**

Dear Patient,

We are pleased to welcome you to our office! Please fill out this questionnaire at your convenience *prior* to your appointment, but bring it with you the *day of* the appointment. Should you have any difficulty with any of the questions, answer to the best of your ability. Try not to leave any answer blank.

Enclosed you will find a map to locate our office. At the end of this packet, we have enclosed a Record Release Form for additional records that you feel would be important. If there are any recent Labs, Scans, and/or X-rays that you think may be important, please try to have these made available to us at the time of your appointment. ***Send the form enclosed on the last page of this form to your Referring doctor.*** If the Records are difficult to obtain, we can usually work without them.

If you need to cancel or reschedule your appointment for any reason, please give us 48 hours notice. It is our policy to charge for appointments that are missed, or those not cancelled within 48 hours. Unfortunately, insurance does not cover these charges.

All Co-pays are due upon check-in. Unfortunately, we are unable to accept Credit Cards at this time. Checks or Cash are accepted and we will give you a Receipt.

For prescription refills or renewals, please contact your Pharmacy at least 48 hours in advance, so they can fax us their forms.

Lastly, we look forward to meeting you and helping serve your Endocrinology-related needs. Our goal is to build a partnership with you. If you do not understand a treatment, medications, or any other aspect of your healthcare, please let us know. We want you to be completely satisfied with the care you receive in our office. Please let us know if you have any additional concerns you would like us to address. If at any time you need any additional clarification about our office policies, please do not hesitate to contact our office directly.

Sincerely,

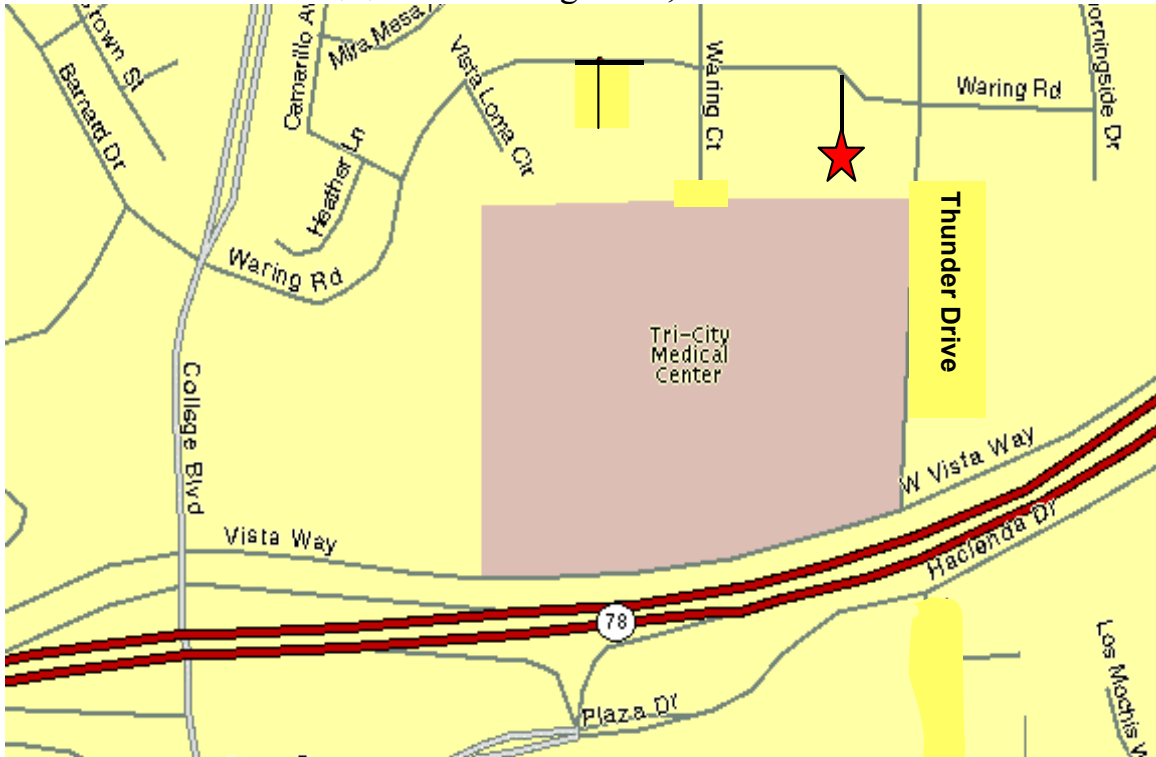
*Chris K. Guerin, Derek D. Mafong and Staff*

Chris K. Guerin, M.D., F.A.C.E./Derek D. Mafong, M.D.  
CKG/DDM/cs

*Revised 6/27/07*

**Map to Office**

★ 3927 Waring Road, Suite C

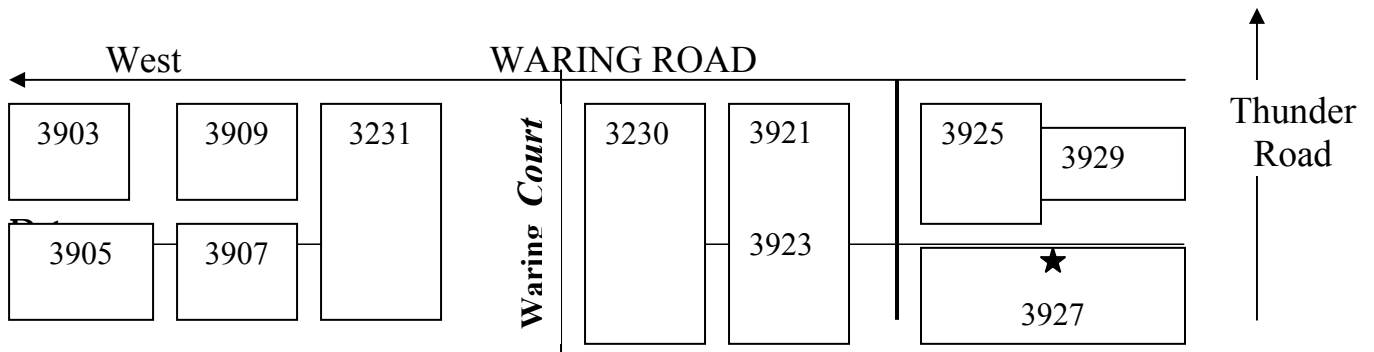


**Written Directions**

The easiest way to get to the office is from I-78 and College Blvd. Head North and take a right on Waring Road (behind the Stop and Go, and Home Depot). Go approximately 3/4 mile through a Residential area until you get to the last group of offices on the Right hand side of the street. Turn Right into the last *driveway*, not Waring Ct., before Thunder. The Office is located in the building marked 3927, located in the back. We are in Suite C.

**Record Release**

The last page of this packet contains a form if you think any records will be helpful for us to have. You can mail, bring, or fax this form *to your referring or previous doctor*. If you are unable to get records, we can usually work without them. Drs. Guerin and Mafong can update the lab and obtain a baseline at the first visit.



NAME \_\_\_\_\_ Age \_\_\_\_\_ Gender M \_\_\_\_\_ F \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Primary Doctor \_\_\_\_\_ Referred by \_\_\_\_\_

**CHIEF COMPLAINT:**

List the main problems that you have and the approximate onset of each:

- |          | <u>Date</u> |
|----------|-------------|
| 1. _____ | _____       |
| _____    | _____       |
| 2. _____ | _____       |
| _____    | _____       |
| 3. _____ | _____       |
| _____    | _____       |

**PERSONAL HISTORY:**

Where were you born? (City, State or Country) \_\_\_\_\_ Date \_\_\_\_\_

Have you ever contracted any illness while outside the U.S.? (If so, what, when, & where)

\_\_\_\_\_

Have you been out of the U.S. in the last 6 months? (If so, list the date and place)

\_\_\_\_\_

What is your current occupation? \_\_\_\_\_

List past occupations: 1. \_\_\_\_\_ 2. \_\_\_\_\_

**MEDICAL HISTORY:**

List all the surgical operations you have had, in chronological order, indicating the year and hospital in which each one was done.

<u>Operation</u>	<u>Hospital &amp; City</u>	<u>Year</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all hospital admissions, other than the surgical operations or delivery of children, in chronological order.

<u>Reason for Admission</u>	<u>Hospital &amp; City</u>	<u>Year</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had (if answer is "Yes," indicate age)

Tuberculosis _____	Skin Cancer _____	Cholesterol _____
Rheumatic Fever _____	Asthma _____	Shingles _____
Diabetes _____	Mumps _____	Venereal Disease _____
Psoriasis _____	Eczema _____	Anemia _____
Hypertension _____	Gout _____	Cancer _____
Denial of Insurance _____	Unusual Childhood Diseases _____	

**FAMILY HISTORY:** Please give the following information about your family:

RELATIONSHIP	LIVING (Yes/No)	CURRENT AGE OR AGE OF DEATH	STATE OF HEALTH OR CAUSE OF DEATH/ ? DIABETES
Father	_____	_____	_____
Mother	_____	_____	_____
Ethnicity of father	_____	_____	Ethnicity of mother _____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

**Have any blood relatives ever had any of the following diseases? (Indicate relationship)**

Diabetes \_\_\_\_\_ Gout \_\_\_\_\_ High blood pressure \_\_\_\_\_ Thyroid \_\_\_\_\_

Osteoporosis \_\_\_\_\_ Heart disease \_\_\_\_\_ Alcoholism \_\_\_\_\_

Epilepsy \_\_\_\_\_ Kidney stones \_\_\_\_\_ Gallstones \_\_\_\_\_ Mental disease \_\_\_\_\_

Bleeding disorders \_\_\_\_\_ Allergy \_\_\_\_\_ Strokes \_\_\_\_\_

Tuberculosis \_\_\_\_\_ Rheumatoid Arthritis \_\_\_\_\_ Glaucoma \_\_\_\_\_

Cancer \_\_\_\_\_ Other \_\_\_\_\_

Any other disease that runs in the family? \_\_\_\_\_

**MEDICATIONS:**

List all the medications you are taking currently. List the name of each, how much you are taking (the strength of each dose and how often you take it) and how long you have been taking it. (Include hormones, Vitamins, tranquilizers, water or salt pills, sleeping pills, diet pills, aspirin, any medication containing aspirin or "cold tablets", etc. It most important that this be answered accurately and in detail: therefore, consult if necessary, with members of your family, your other physicians, and your pharmacist.)

Name of Medicine	Strength	How Often Taken	How Long Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Drug Allergies**

List all drugs to which you are allergic and note your reaction to the medicine:

1. \_\_\_\_\_ Reaction \_\_\_\_\_

2. \_\_\_\_\_ Reaction \_\_\_\_\_

**HABITS:**

ALCOHOL – How much and how often \_\_\_\_\_

Have you ever tried to "cut down" or modify your drinking? Yes  No

TOBACCO – How much and how often \_\_\_\_\_

Have you ever smoked heavily? Yes  No  If yes, when did you quit? \_\_\_\_\_

**FOR WOMEN:**

How many pregnancies \_\_\_\_\_ How many children \_\_\_\_\_  
How many normal vaginal deliveries \_\_\_\_\_ How many Cesarean Sections \_\_\_\_\_  
Last Pap smear:  normal  abnormal / Last Mammogram:  normal  abnormal  
When \_\_\_\_\_ Where \_\_\_\_\_  
Do you take calcium supplements? Yes  No   
How much?

**FOR MEN:**

Do you have a lack of energy? Yes  No   
Do you have a decrease in strength, endurance, or both? Yes  No   
Have you lost height? Yes  No   
Have you noticed a decreased enjoyment of life? Yes  No   
Are you sad, grumpy, or both? Yes  No   
Have you noticed a recent deterioration in your ability to play sports? Yes  No   
Are you falling asleep after dinner? Yes  No   
Has there been a recent deterioration in your work performance? Yes  No   
Do you have a decrease in libido (sex drive)? Yes  No   
Are your erections less strong? Yes  No

**FOR DIABETIC PATIENTS ONLY-(ALL OTHER PATIENTS GO TO PAGE 8)**

How long have you had Diabetes? \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

How was it diagnosed? i.e. routine lab test? Yes \_\_\_\_\_ Other \_\_\_\_\_

Symptomatic? (Circle below) Yes \_\_\_\_\_ No \_\_\_\_\_

(i.e. excessive thirst, urination, or unexplained weight loss) \_\_\_\_\_

Have you ever been hospitalized due to Diabetes and/or complications?

Explain \_\_\_\_\_

Medications for Diabetes:

Oral Agents (Type and Dose) \_\_\_\_\_

Insulin (Type and Dose) \_\_\_\_\_

Where do you give your injections? \_\_\_\_\_

Any bruises or problems with injections? \_\_\_\_\_  
Do you do Self Blood Glucose Monitoring? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, what type of machine? \_\_\_\_\_

How often do you test? \_\_\_\_\_ times per week; at what time? \_\_\_\_\_

Results before meals: \_\_\_\_\_ Results after meals (2 hours): \_\_\_\_\_

Do you follow a Diabetes Diet? Yes \_\_\_\_\_ No \_\_\_\_\_

Would you like to attend Classes on Diabetes taught by a Certified Diabetes Nurse Educator and Certified Diabetes Dietitian? Yes \_\_\_\_\_ No \_\_\_\_\_

If known, most recent HbA1C result: \_\_\_\_\_ mg/dl

When done? \_\_\_\_\_

Have you had any **Low blood sugar** reactions in the past 6 months?

Explain (what caused and how they were treated):

\_\_\_\_\_

Do you usually have **High blood sugar** readings at any particular time of day?

Explain (what caused and how they were treated):

\_\_\_\_\_

Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_

What type? \_\_\_\_\_ How many times per week? \_\_\_\_\_

Other stresses in life? \_\_\_\_\_

Complications Related to Diabetes:

Eyes Last exam by Ophthalmologist, or Optometrist: \_\_\_\_\_

Heart Any heart condition (i.e. CABG, angina, MI, none) \_\_\_\_\_

Kidney Last check for microalbuminuria \_\_\_\_\_

Feet Infection? Yes \_\_\_\_\_ No \_\_\_\_\_

Pain or loss of sensation? Yes \_\_\_\_\_ No \_\_\_\_\_

## REVIEW OF SYSTEMS:

### GENERAL HEALTH

Do you think that, on the whole, your health is good? Yes  No

How is your overall "pep" or energy now, as compared with a year ago?

Increased \_\_\_\_\_ Decreased \_\_\_\_\_ About the same \_\_\_\_\_

What is your average weight? \_\_\_\_\_ Any recent change of weight? \_\_\_\_\_

What is the most you have ever weighed? \_\_\_\_\_

What is the least you have ever weighed as an adult? \_\_\_\_\_

Do you have routinely: Fever? \_\_\_\_\_ Chills? \_\_\_\_\_ Rashes? \_\_\_\_\_

Do you sleep well? Yes  No  How many hours? \_\_\_\_\_

Do you exercise regularly? Yes  No  What type of exercise? \_\_\_\_\_

### SPECIAL SENSES

Have you had any of the following recently?

Frequent Blurred Vision	<u>Yes</u>	<u>No</u>	Other serious eye disease	<u>Yes</u>	<u>No</u>	Frequent colds	<u>Yes</u>	<u>No</u>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Change in voice	<input type="checkbox"/>	<input type="checkbox"/>	Bloody noses	<input type="checkbox"/>	<input type="checkbox"/>
Severe pain in the eye	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>						

Do you wear glasses \_\_\_\_\_ Since when \_\_\_\_\_ When was your last exam \_\_\_\_\_

Abnormal noises in the ear (hissing, buzzing, whistling, ringing, roaring, etc.) \_\_\_\_\_

### CHEST AND LUNG

Have you ever had any of the following?

Pneumonia	<u>Yes</u>	<u>No</u>	Asthma	<u>Yes</u>	<u>No</u>	Serious chest or lung trouble?	<u>Yes</u>	<u>No</u>
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Valley Fever	<input type="checkbox"/>	<input type="checkbox"/>	Coughed up blood?	<input type="checkbox"/>	<input type="checkbox"/>
Fluid on the lungs	<input type="checkbox"/>	<input type="checkbox"/>	Desert Fever	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Emboli	<input type="checkbox"/>	<input type="checkbox"/>

When was your last chest x-ray? \_\_\_\_\_ Where was it taken? \_\_\_\_\_

Was it normal or abnormal? \_\_\_\_\_

### CIRCULATORY SYSTEM

Have you ever had any of the following?

Heart trouble	<u>Yes</u>	<u>No</u>	Heart failure	<u>Yes</u>	<u>No</u>	Toxemia of pregnancy	<u>Yes</u>	<u>No</u>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or coronary	<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

Do you frequently have?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
If you have leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	a) that awakens you at night	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Do you have them at night	<input type="checkbox"/>	<input type="checkbox"/>	b) going up stairs	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
? on walking	<input type="checkbox"/>	<input type="checkbox"/>	c) walking how many blocks	<input type="checkbox"/>	<input type="checkbox"/>			

Have you had problems with?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Fluid on the Lungs	<input type="checkbox"/>	<input type="checkbox"/>

## DIGESTIVE SYSTEM

Have you ever had or been told that you had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Worms or parasites	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Sore Tongue	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones or gallbladder trouble	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Any GI tumor	<input type="checkbox"/>	<input type="checkbox"/>

Do you have problems with?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Food sticking in throat	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Choking	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	Do you use antacids?	<input type="checkbox"/>	<input type="checkbox"/>

Specific Food Intolerance? \_\_\_\_\_

## URINARY SYSTEM

Have you ever had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Kidney trouble	<input type="checkbox"/>	<input type="checkbox"/>	Urine or kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Protein in urine	<input type="checkbox"/>	<input type="checkbox"/>	Blood or pus in urine	<input type="checkbox"/>	<input type="checkbox"/>
Albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	Other kidney/urine disease	<input type="checkbox"/>	<input type="checkbox"/>
Prostate trouble	<input type="checkbox"/>	<input type="checkbox"/>	Do you empty your bladder well?	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Hesitancy on urination	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Does urine leak with coughing, sneezing, or straining?	<input type="checkbox"/>	<input type="checkbox"/>	Has your Bladder control changed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get up at night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	How many times do you urinate in an average day? _____		
			If so, how often _____		

## BLOOD

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>

Have you ever had a transfusion?    
 Have you ever needed to take iron?    
 Have you ever been anemic?    
 Do you bruise easily?

Do your gums bleed?    
 Do you bleed easily?    
 Have you had lymph gland enlargement?    
 Is there any history of abnormal bleeding  
 Or, in your family?

### GLANDULAR

Have you had any of the following problems?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair	<input type="checkbox"/>	<input type="checkbox"/>
Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Brittle Nails	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Diminished sex drive	<input type="checkbox"/>	<input type="checkbox"/>
Did you ever take thyroid medication?	<input type="checkbox"/>	<input type="checkbox"/>	"Borderline" Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

### NEUROLOGICAL

Have you had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in speaking	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric condition	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in coordination	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Depression	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Muscular disease	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in walking	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Change in memory	<input type="checkbox"/>	<input type="checkbox"/>

Frequent or recurrent headaches \_\_\_\_\_ What medication used? \_\_\_\_\_

### JOINTS

Have you had any of the following problems?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Fractured bones	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of the joints	<input type="checkbox"/>	<input type="checkbox"/>
Disc problem	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Taken medication for arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Morning Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Deformities	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>

*Thank You for Filling Out This Form!*

# Tri-City Endocrinology and Metabolism

## Authorization for Release of Medical Information



RE: \_\_\_\_\_  
(Your Name)

Date of Birth: \_\_\_\_\_

I hereby authorize and request \_\_\_\_\_  
(Primary or Referring Doctor's Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_

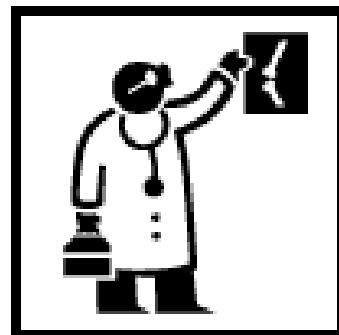
to furnish the following information concerning my medical history and condition:

- History and Physical Examination
- Recent Laboratory Reports, such as HbA1C, Lipid values, and Thyroid Function tests, if done within last year
- Ultrasound Reports, Scans, and/or X-rays
- Operative and Pathology Reports

My appointment is on \_\_\_\_\_ (Date)

Please *mail* promptly to:

Chris K. Guerin, M.D., F.A.C.E.  
Derek D. Mafong, M.D.  
Tri-City Endocrinology and Metabolism  
3927 Waring Road, Suite C  
Oceanside, CA 92056



*Or give to patient to hand carry in.*

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_ (Your Name)