Tri-City Endocrinology and Metabolism

3927 Waring Road, Suite C
Oceanside, CA 92056
(760) 941-9850

Advanced Metabolic Care and Research

700 West El Norte Parkway, Suite 201
Escondido, California 92026
(760) 743-1431

28441 Rancho California Road, Suite 104
Temecula, California 92591
(951) 699-4601

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 page 11 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 at least 24 hours notice. **It is our policy to charge for appointments that are missed, or those not cancelled within 24 hours. Unfortunately, insurance does not cover these charges.**

All Co-pays are due upon check-in. Checks, Cash, or Credit Cards (Visa MasterCard or Discover) 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, M.D., Alan B. Douglass, M.D. and Staff

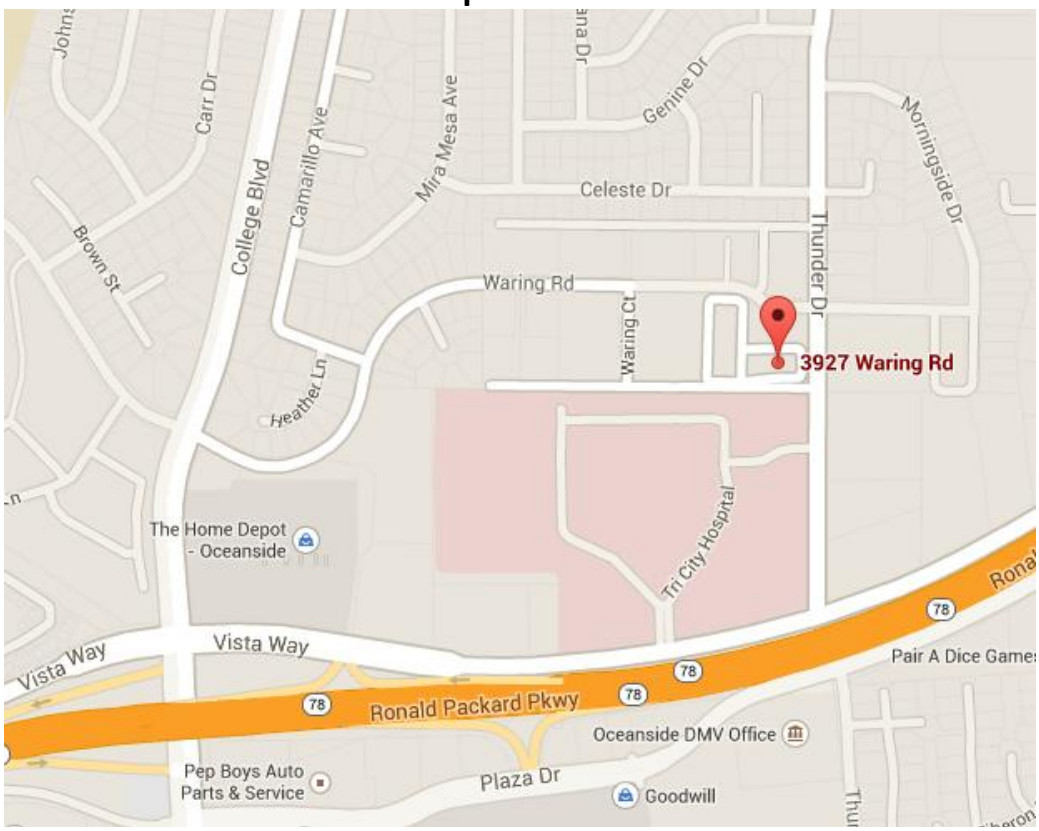
Chris K. Guerin, M.D., F.A.C.E. Alan B. Douglass, M.D. F.A.C.E.

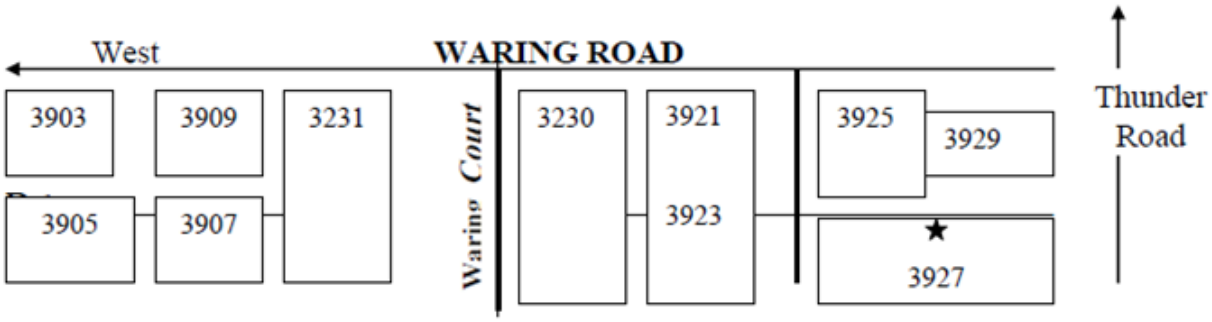
I have read the above and agree to the office policies

Patient Signature_____ Date_____

Revised 6/4/14

Map to Office





Written Directions

We are on the corner of Waring Rd and Thunder Dr. The easiest way to get to the office is from I-78 and College Blvd. Head north and take a right on Waring Road not Waring CT (behind the Circle K, 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*, before Thunder. The Office is located in the building marked 3927 Suite C, located in the back.

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, so that we can have these records at the time of your appointment*.** If you are unable to get records, we can usually work without them.

NAME: _____ Age: ____ Gender: Male ___ Female ___

Primary Doctor _____ Referred by _____

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

Date

1. _____ _____
   _____
   _____
2. _____ _____
   _____
   _____
3. _____ _____
   _____
   _____

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 is 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**

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

Diabetes: _____	Hypertension: _____	High cholesterol: _____
Thyroid Disease: _____	Gout: _____	Cancer: _____
Eczema: _____	Heart Trouble: _____	Leg/Foot Ulcers: _____
Peptic Ulcers: _____	Hiatal Hernia: _____	Colitis: _____
Kidney Trouble: _____	Stroke: _____	Rheumatic Fever: _____
Psoriasis: _____	Asthma: _____	Mumps: _____
Shingles: _____	Venereal Disease: _____	Anemia: _____
Heart Murmur: _____	Liver Disease: _____	Hepatitis: _____
Pancreatitis: _____	Hemorrhoids: _____	Protein in Urine: _____
Kidney Stones: _____	Glaucoma: _____	Blood Transfusion: _____
Valley Fever: _____	Desert Fever: _____	Emphysema: _____
Blood Clots: _____	Heart Failure: _____	Fluid on Lungs: _____
Diverticulitis: _____	Gallbladder Disease: _____	Prostate Trouble: _____
Muscular Disease: _____	Depression: _____	Anxiety: _____
Unusual Childhood Diseases: _____		Denial of Insurance: _____

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

1. _____ Reaction _____
2. _____ Reaction _____

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

Year	**Operation**	**Hospital & City**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Year	**Reason for Hospitalization**	**Hospital & City**
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Please give the following information about your family:

	LIVING?	YEAR OF BIRTH	AGE	DIABETES?	HYPERTENSION?	HEART DISEASE?	STROKE?	CANCER?	MENTAL ILLNESS?	HYPOTHYROIDISM?	OTHER CONDITIONS? (list)
Father	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for father: ______________________________

Mother	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for mother: ______________________________

Brother	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for brother: ______________________________

Brother	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for brother: ______________________________

Brother	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for brother: ______________________________

Sister	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for sister: ______________________________

Sister	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for sister: ______________________________

Sister	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for sister: ______________________________

Spouse	□Yes □No			□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No	□Yes □No

Other health issues for spouse: ______________________________

Children? □Yes □No How many boys? _____ How many girls? _____

Please list any other diseases that run in your family:

PERSONAL HISTORY

TOBACCO:

Are you a: ☐ Current smoker ☐ Former smoker ☐ Non-smoker	If you are a smoker: How often do you smoke? ☐ Every day ☐ Some days, but not every day	If you are a smoker: How many cigarettes a day? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more	If you are a smoker: How soon after you wake up do you smoke your 1st cigarette? ☐ Within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ after 60 minutes	If you are a smoker: Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit
If you are a former smoker, when did you quit? _____				

ALCOHOL:

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No	If "yes," how often did you have a drink containing alcohol in the past year? ☐ Never ☐ Monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week	If "yes," how many drinks did you have on a typical day when you were drinking in the past year? ☐ 1 or 2 drinks ☐ 3 or 4 drinks ☐ 5 or 6 drinks ☐ 7 to 9 drinks ☐ 10 or more drinks	If "yes," how often did you have 6 or more drinks on one occasion in the past year? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

MISCELLANEOUS:

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

Do you exercise? ☐ Yes ☐ No
If yes, what exercise do you do and how often? _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What is your current occupation? _____

List past occupations: 1. _____ 2. _____

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

_____

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

_____

REVIEW OF SYSTEMS

GENERAL / CONSTITUTIONAL:

	Yes	No		Yes	No		Yes	No
Do you think that, on the whole, your health is good?	☐	☐	Do you routinely have fevers?	☐	☐	Do you routinely have rashes?	☐	☐
Have you been feeling unusually fatigued?	☐	☐	Do you routinely have chills?	☐	☐			
Have you been feeling lightheaded?	☐	☐	Do you sleep well?	☐	☐	How many hours of sleep do you get?	_____	
Have you had abnormal weight gain?	☐	☐	If yes, how many pounds have you gained or lost?	_____		What is the most you have ever weighed?	_____	
Have you had abnormal weight loss?	☐	☐	Over what period of time has this weight change occurred?	_____		What is the least you have ever weighed?	_____	

OPHTHALMOLOGIC (EYES):

Have you had:

	Yes	No		Yes	No		Yes	No
Blurred vision?	☐	☐	Bulging of the eyes?	☐	☐			
Double vision?	☐	☐	Difficulty closing your eyes?	☐	☐	Pain with eye movement?	☐	☐
Eye pain?	☐	☐	A gritty feeling in your eyes?	☐	☐	Loss of peripheral vision?	☐	☐

ENT:

Have you had:

	Yes	No		Yes	No		Yes	No
Ringing in the ears?	☐	☐	A feeling of pressure or fullness in your neck?	☐	☐	Food sticking in throat?	☐	☐
Decreased hearing?	☐	☐	Hoarse voice?	☐	☐	A lump in your neck?	☐	☐

ENDOCRINE:

Have you had:

	Yes	No		Yes	No		Yes	No
Excessive thirst?	☐	☐	Unusual increase in body odor?	☐	☐	Abnormal deepening of your voice?	☐	☐
Frequent urination?	☐	☐	Excessive sweating?	☐	☐	Do you feel colder than others around you?	☐	☐
Dry mouth?	☐	☐	Recent change in your foot/shoe size?	☐	☐	Do you feel warmer than others around you?	☐	☐
			Recent change in your hand/ring size?	☐	☐	Is your sex drive decreased?	☐	☐

RESPIRATORY:

Have you had:

	Yes	No		Yes	No		Yes	No
Shortness of breath at rest?	☐	☐	Chronic or frequent cough?	☐	☐	Blood in sputum (coughed up blood)?	☐	☐
Shortness of breath with exertion?	☐	☐	Chronic or frequent wheezing?	☐	☐			

CARDIOVASCULAR:
Have you had:

	Yes	No		Yes	No		Yes	No
Heart palpitations?	☐	☐	Swelling in your legs?	☐	☐			
Irregular heartbeat?	☐	☐	Chest pain at rest?	☐	☐	Leg cramps with walking?	☐	☐
Rapid heartbeat?	☐	☐	Chest pain with exertion?	☐	☐	Leg cramps at night?	☐	☐

GASTROINTESTINAL:
Have you had:

	Yes	No		Yes	No		Yes	No
Abdominal pain?	☐	☐	Constipation?	☐	☐	Change in your bowel habits?	☐	☐
Abdominal cramps?	☐	☐	Diarrhea?	☐	☐	Trouble swallowing?	☐	☐
Nausea?	☐	☐	Decreased appetite?	☐	☐	Heartburn?	☐	☐
Vomiting?	☐	☐	Difficulty swallowing?	☐	☐			

HEMATOLOGY:

	Yes	No		Yes	No		Yes	No
Do you bruise easily?	☐	☐	Do your gums bleed?	☐	☐	Have you had lymph gland enlargement?	☐	☐
Do you have abnormal or prolonged bleeding?				☐	☐			

WOMEN ONLY:

Number of pregnancies? _____ Number of children? _____
Number of normal vaginal deliveries? _____ Number of cesarean sections? _____
Last pap smear: Date: _____ Where? _____ ☐normal ☐abnormal
Last mammogram: Date: _____ Where? _____ ☐normal ☐abnormal

Have you had:

	Yes	No		Yes	No
Missed periods?	☐	☐	Hot flashes?	☐	☐
Irregular periods?	☐	☐	Abnormal hair growth on your face?	☐	☐
Have you had vaginal bleeding between periods?	☐	☐	Abnormal hair growth on your chest?	☐	☐
Have you had unusually heavy bleeding during menses?	☐	☐	Abnormal hair growth on your abdomen?	☐	☐

MEN ONLY:

	Yes	No		Yes	No		Yes	No
Do you have a lack of energy?	☐	☐	Are you sad, grumpy, or both?	☐	☐	Do you have a decrease in your sex drive?	☐	☐
Do you have a decrease in strength, endurance, or both?	☐	☐	Have you noticed a recent deterioration in your ability to play sports?	☐	☐	Are your erections less strong?	☐	☐
Have you lost height?	☐	☐	Are you falling asleep after dinner?	☐	☐	Do you have difficulty initiating a urine stream?	☐	☐
Have you noticed a decreased enjoyment of life?	☐	☐	Has there been a recent deterioration in your work performance?	☐	☐	Do you have dribbling after urination?	☐	☐
						Do you feel that you are unable to empty your bladder completely?	☐	☐

GENITOURINARY:
Have you had:

	Yes	No		Yes	No		Yes	No
Difficulty urinating?	☐	☐	Painful urination?	☐	☐	Blood in your urine?	☐	☐
Urinary incontinence?	☐	☐	Do you have to get up at night to urinate?	☐	☐	→ If yes, how often? _____		

MUSCULOSKELETAL:
Have you had:

	Yes	No		Yes	No		Yes	No
Cramps in your legs?	☐	☐	Chronic back pain?	☐	☐	Joint stiffness?	☐	☐
Calf pain when walking?	☐	☐	Sciatica (shooting pains into leg)?	☐	☐	Painful joints?	☐	☐
Leg cramps at night?	☐	☐	Swollen joints?	☐	☐			

SKIN:
Have you had:

	Yes	No		Yes	No		Yes	No
Dry skin?	☐	☐	A rash?	☐	☐	Stretch marks?	☐	☐
Brittle nails?	☐	☐	Recent acne?	☐	☐	Loss of hair?	☐	☐
Areas where you have lost skin pigment (vitiligo)?				☐	☐	Itching?	☐	☐

NEUROLOGIC:
Have you had:

	Yes	No		Yes	No		Yes	No
Headaches?	☐	☐	Numbness in your feet?	☐	☐	Seizures (convulsions)?	☐	☐
Tremor?	☐	☐	Tingling in your feet?	☐	☐			
Episodes of fainting?	☐	☐	Burning in your feet?	☐	☐	Have you lost the use of an arm or leg (for instance, due to a stroke)?	☐	☐
Episodes of dizziness?	☐	☐	Loss of strength?	☐	☐			

PSYCHIATRIC:
Have you had:

	Yes	No		Yes	No		Yes	No
Severe mood swings?	☐	☐	Unusual anxiety?	☐	☐	Panic attacks?	☐	☐
Difficulty sleeping?	☐	☐	Depressed mood?	☐	☐	Spells of anxiety, headaches, and sweats?	☐	☐
Mental fatigue?	☐	☐	Have you contemplated suicide?	☐	☐			
Are there severe stressors in your life right now? If so, briefly list:	☐	☐	_____					

FOR DIABETIC PATIENTS ONLY

How long have you had Diabetes? _____ yrs. _____ mos.

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

Symptomatic? (Circle) Yes _____ No _____ (i.e. excessive thirst, urination, or unexplained weight loss, other _____)

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

Explain _____

Medications for Diabetes:

Oral Agents (Type and Dose) _____

Insulin Pens or Vials _____

Type of Insulin 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 times? _____

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): _____

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 _____

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)
_____

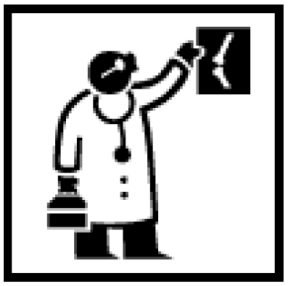
to furnish the following information concerning my medical history and condition:

- ❑ 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 or fax* promptly to:

Tri-City Endocrinology and Metabolism
3927 Waring Road, Suite C
Oceanside, CA 92056
Phone: 760-941-9850
Fax: 760-941-9845



Or *give to patient to hand carry in.*

DATE: _____ SIGNED: _____ (Your Name)

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form. If you have any questions, we'll be glad to help you.

Last Name _____ First _____ M.I. ____AGE ____SEX _____

Address _____ City _____State _____ ZIP _____

Date of Birth _____ Marital Status _____ Cell Phone _____

Phone (Home) ( ) _____ (Work) ( ) _____

Social Security No. _____ E-Mail Address _____

Occupation _____ Employed by _____

Name of Spouse _____ Occupation _____

Employed by _____ Phone (work) _____

Name and Phone of closest Relative/Friend (in emergency)

Name_____ Phone_____

Name of party responsible for bill _____

Relationship to patient _____ Phone_____

Address _____ City _____ State _____ ZIP_____

Referred by or Primary Care Provider: _____

PLEASE PRESENT ALL INSURANCE CARDS AT THE FRONT DESK

Name of *Primary* insurance company _____

Policy no. _____ Group no. _____

Deductible $ _____ Co-payment _____

Name of *Secondary* insurance company _____

Policy no. _____ Group no. _____

Deductible $ _____ Co-payment _____

MEDICARE: This Office will file all Medicare Claims and accepts Medicare assignment. We will bill Medicare and one secondary Insurance. The patient is responsible for all deductibles and any co-payments not covered by their supplemental insurance.

INSURANCES: Most HMO's and some PPO's require pre-authorization for services. If pre-authorization is not obtained and/or the HMO/PPO refuses to cover within 60 days, the patient is responsible for services rendered. If unsure of coverage, contact your HMO/PPO.

LABORATORY: Laboratory work charges are billed by the Lab and are separate from our Services. It is always a good idea to check with your Insurance Company to be sure the Lab studies are covered and that the lab has a current contract to provide services.

I have read and understood all of the above and give my consent for medical treatment. We follow HIPAA Guidelines (copy available upon request). I hereby authorize Chris K. Guerin M.D., F.A.C.E. and/or Alan B. Douglass, M.D., F.A.C.E. to release any medical and/or billing information to my insurance company and/or my Referring or Consulting Health Care Providers.

***Patient Signature _____ Date _____**

Tri-City Endocrinology and Metabolism

3927 Waring Road, Suite C
Oceanside, CA 92056
(760) 941-9850

PERMISSION TO FURNISH MEDICAL INFORMATION

Please list people to whom we may furnish medical information about you (example: blood test results, other test results, doctor instructions, etc.) in the event you are not immediately available. Unless otherwise indicated, we will leave a message on your answering machine or voice mail with any routine results or instructions when you are not immediately available.

THIS AUTHORIZATION WILL BE IN EFFECT UNTIL REVOKED IN WRITING

Approved Person(s):	**Relationship to you:**
_____	_____
_____	_____
_____	_____

_____ Initial here if you wish us to furnish information ONLY to you. In this instance, we will leave a message for you to call our office if you are not immediately available.

_____	_____
Name (please print)	**Date of Birth**
_____	_____
Signature	**Date**