HH Endocrinology & Diabetes Clinic

Dear Patient,

Welcome to Huntsville Hospital Endocrinology & Diabetes Clinic. Thank you for trusting us with your care. We would like to take the opportunity to introduce you to our physician and familiarize you with our practice. This will ensure that we are able to provide you with the best care and respect possible.

Huntsville Hospital Endocrinology & Diabetes Clinic cares for patients with diabetes and other endocrine disorders. Led by Ankur Jindal, MD, MBBS, ECNU, our team is committed to providing quality care and compassionate service. Dr. Jindal is board certified in internal medicine and has earned Endocrine Certification in Neck Ultrasound and Fine Needle Aspiration. He completed his residency at the University of Pittsburgh Medical Center (Mercy Hospital) in Pittsburgh, PA and a fellowship in Endocrinology and Metabolism at the University of Missouri. He enjoys working alongside the patient to ensure that every question is answered and that each patient is an active participant in their care.

With that being said, the clinic prides itself on making every effort possible to see each patient on time. We value and respect your time. As such, we do ask that you ARRIVE 30 MINUTES prior to your appointment. This will allow us to gather the appropriate paperwork and information necessary to provide the quality care you expect and deserve. If you are running late, please call the office at 256-265-0780 as soon as possible. We are happy to assist you in rescheduling your appointment to a time that is more convenient for you. If you should need to cancel your appointment, please provide us with a 24 hour notice so that we can offer the appointment time to another patient on our waiting list.

Please feel free to visit our website and explore the wide variety of patient education that Dr. Jindal has selected. It is important to note that while you are seeing Dr. Jindal, you will need to maintain a Primary Care Physician. This will allow for seamless coordination of care and thus ensure that you are receiving the best care possible at all times. If you change your Primary Care Physician, please let our staff know so that we can update your records accordingly.

Thank you again for choosing Huntsville Hospital Endocrinology & Diabetes Clinic. We appreciate the faith and trust you are placing in us. We will do our best to ensure that you receive the quality care you expect and deserve. Please do not hesitate to call with any questions or concerns. We are always here to serve and support you.

Sincerely,

HH Endocrinology & Diabetes Clinic

Appointment Information:

Day:_____ **Date:_____**

Arrival Time:_____ **Appointment Time: _____**

*****Please note it is important to arrive on time. This allows us to provide every patient with the care, respect and timeliness that they deserve.***

****Please bring your glucometer and blood glucose logs if applicable.***

HH Endocrinology & Diabetes Clinic

201 Sivley Road, Suite 440
Huntsville, AL 35801
Phone (256) 265-0780 Fax (256) 265-0781

Patient Information

Date _____

Please Print
Patient's Name _____ Referred By _____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Work Phone _____

SSN _____-_____-_____ Sex M F Date of Birth _____-_____-_____

Email Address _____

Patient's Occupation _____ Employer _____

Employer's Address _____ Employer's Phone _____

Spouse's Name _____ Spouse's DOB _____-_____-_____ Spouse's SSN _____-_____-_____

Spouse's Occupation_____ Spouse's Employer _____

Employer's Address _____ Employer's Phone _____

Notify in case of emergency _____ Relationship _____

City _____ State _____ Zip _____ Phone _____

If patient is a minor, list persons other than the responsible party above, who have permission to bring child to the office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's SSN	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's SSN	Insured's Date of Birth
Insurance Company Name	

Person responsible for this account _____ Phone _____

I agree that the payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collections, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Endocrinology & Diabetes Clinic to release information to insurance carriers and for insurance carriers to release information to HH Endocrinology & Diabetes Clinic concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignments applies.

Signature _____Date _____ Time _____

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history. Information contained here will be released only if you have authorized us to do so.

Endocrinology & Diabetes Clinic

Last Name:	First Name:	Middle Initial:
Date of Birth: / /	Gender: ○ Male ○ Female	Marital Status:
Preferred Pharmacy:	Pharmacy Phone Number:	
Pharmacy Address:		
Primary Care Provider:	Phone:	Referring Doctor:
Being seen today for:		

Past Medical History: *List any conditions you have had.*

Condition	Date

Family History:

parents, grandparents, brothers, sisters, children, aunts, uncles

Yes	No	Disease	Relative(s)
○	○	Asthma	
○	○	Cancer	
○	○	Diabetes	
○	○	Heart Disease	
○	○	High Blood Pressure	
○	○	Kidney Disease	
○	○	Mental Illness	
○	○	Other Glandular Disease	
○	○	Stomach Ulcers	
○	○	Stroke	
○	○	Thyroid Disease/Goiter	
○	○	Tuberculosis	

Health Maintenance: *Fill in all that apply.*

Date of last eye exam:
Date of last prostate exam:
Date of last mammogram:

Past Surgical History:

Type	Year
Recent Hospitalizations:	

Social History:

Do you use alcohol? ○ Never ○Formerly ○ Some Days ○ Every Day
Do you drink caffeinated beverages? ○ Yes ○ No
Have you ever smoked? ○ Never ○ Formerly ○Some Days ○ Every Day If yes, how many years have you smoked? Packs per day?
How often do you exercise? ○ Never ○ 1x per wk ○ 2-3x per wk ○ 4+x per wk
How many children do you have?
Highest level of education?
Occupation:

Symptoms: *Check all appropriate boxes indicating the symptoms you have had within the last year.*

Constitutional
- ○ Change in weight of more than 10 lbs
- ○ Night Sweats
- ○ Fatigue

Eyes
- ○ Trouble with Vision
- ○ Changes in Vision
- ○ Double Vision
- ○ Blurred Vision

Head ENT
- ○ Changes in Hearing
- ○ Hoarseness
- ○ Headaches

Cardiovascular
- ○ Palpitations
- ○ Chest Pain
- ○ Difficulty Breathing on Exertion
- ○ Lower Extremity Swelling
- ○ Loss of Consciousness

Respiratory
- ○ Chronic Cough
- ○ Coughing Blood
- ○ Shortness of Breath
- ○ Wheezing
- ○ Difficulty Breathing

Gastrointestinal
- ○ Difficulty Swallowing
- ○ Reflux
- ○ Nausea
- ○ Vomiting
- ○ Vomiting Blood
- ○ Diarrhea
- ○ Constipation
- ○ Blood in Stools
- ○ Changes in Bowel Habits

Genitourinary
- ○ Painful or Difficult Urination
- ○ Frequency
- ○ Excessive Urination at Night
- ○ Post Void Dribbling
- ○ Blood in Urine
- ○ Urgency

Musculoskeletal
- ○ Muscle Cramps
- ○ Nocturnal Leg Cramps
- ○ Joint Pain
- ○ Joint Swelling

Integument/Skin
- ○ Pigmentation Changes
- ○ Skin Dryness
- ○ Rash
- ○ New Skin Lesions
- ○ Changes to Existing Skin Lesions/Moles
- ○ Hair Growth Changes

Neurologic
- ○ Tremors
- ○ Speech Difficulties
- ○ Paralysis
- ○ Tingling or Numbness
- ○ Seizures
- ○ Muscular Weakness

Psychiatric
- ○ Anxiety
- ○ Depression
- ○ Difficulty Breathing

Endocrine
- ○ Cold Intolerance
- ○ Heat Intolerance
- ○ Drinking More Fluids
- ○ Excessive Urination
- ○ Excessive or Abnormal Thirst
- ○ Excessive Hair Growth
- ○ Hot Flashes

Hema-Lymph
- ○ Lymph Node Enlargement
- ○ Easy Bleeding
- ○ Easy Bruising

Allergic-Immuno
- ○ Sinus Allergy
- ○ Hay Fever
- ○ Allergic Dermatitis

Breasts
- ○ Changes in Skin
- ○ Masses
- ○ Nipple Discharge

Medications: *List all medicines and supplements you take.*

Medicine or Supplement	How much?	How often?

Allergies:

Are you allergic to any medications? ○ Yes ○ No

Please list:

Are you allergic to latex? ○ Yes ○ No

Are you allergic to any foods? ○ Yes ○ No

Please list:

I certify these two pages to be accurate and current to the best of my knowledge. *(Please sign & date below.)*

Patient Signature: _____ **Date:** _____

Name:_____ Date of Birth:_____

Diabetes Questionnaire

****Please note it is important that you bring your glucometer & blood glucose log to each appointment with Dr. Jindal****

1. At what age were you diagnosed with diabetes? _____
2. Do you have a diabetes related complication: (please circle one)

   Retinopathy Kidney Disease Heart Disease Nerve Damage

3. What medications have you tried for diabetes in the past? (If additional space is needed, please write on the back of this page)

Medications	How Much / How Often	Why was it stopped?

4. How many meals do you eat in a day? _____Which meal is your largest?_____
5. How often do you snack?_____
6. What do you usually use for snacking? _____
7. How many sugar sweetened drinks or sodas do you drink daily?_____
8. What was your last A1c and when was it done?_____
9. How often do you check your blood sugar?_____

10. What are your blood glucose readings? Please provide a 50 point average range for each of the options below. (Example 100's-150's)

Before Breakfast Range	Before Lunch Range	Before Supper Range	At Bedtime Range

11. In the last two weeks have you had a blood sugar reading less than 70?_____
12. What time of the day do you usually have a reading less than 70?_____
13. At what Blood Glucose Number do you feel the symptoms of low Blood Glucose? _____
14. Have you ever had pancreatitis or thyroid cancer? If so, which one?_____
15. Who is your eye doctor and when was your last exam?_____
16. Any weight gain or loss in the past six months? _____ How Much? _____
17. Do you stay thirsty? _____
18. Do you have to get up at night to urinate? If so, how often? _____

Endocrinology & Diabetes Clinic

Name: _____ Date of Birth: _____

Thyroid Questionnaire

1. Have you been diagnosed with thyroid disease? If yes, please circle the diagnosis:

Hypothyroidism Hashimoto's Thyroiditis Graves Disease

Hyperthyroidism Thyroid nodule Goiter Thyroid cancer

2. Have you taken any treatment for thyroid disease? If yes, please indicate treatment type. _____

_____

3. What medications have you tried for Thyroid Disease in the past? (If additional space is needed, please write on the back of this page)

Medications	How Much / How Often	Why was it stopped?

4. Have you received contrast for a CT scan in the last 6 months? If yes, when? _____

5. Do you take, or have you ever taken, Amiodarone, lithium, or thyroid supplements? If yes, please indicate which one._____

6. Has your weight changed in last 6 months? If yes, how much did you loose or gain? _____

7. Do you have (please circle if it applies): difficulty breathing difficulty swallowing changes in voice

8. Does anyone in your family have thyroid cancer? If yes, please indicate who it is and the type of thyroid cancer. _____

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Name: _____ Date of Birth: _____

9. Have you received radiation to the head and neck before age 20?_____

10. Have you been diagnosed with cancer? If yes, what type of cancer?_____

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132 Request for Health information from hospitals or other providers

Name of Organization/Facility: _____

Address: _____

Phone/Fax: _____

Huntsville Hospital Requests Information for the following Patient:

Patient Name: _____ SSN(Opitional) _____

Date of Birth: _____ Phone: _____ Date of Service: _____

Address: _____

Signature: _____

Requested information for treatment, payment, or operations:

☐ Discharge Summary	☐ Consultation Report	☐ Outpatient Record
☐ History and Physical	☐ EKG Report	☐ Emergency Dept Record
☐ Operative Note	☐ Nurses' Notes	☐ Laboratory Results
☐ Pathology Report	☐ Progress Notes	☐ Imaging Results
	☐ Physicians' Orders	☐ Other_____

_____

_____

_____

Please send to:
HH Endocrinology & Diabetes Clinic
201 Sivley Road, Suite 440
Huntsville, AL 35801
Phone (256) 265-0780
Fax (256) 265-0781

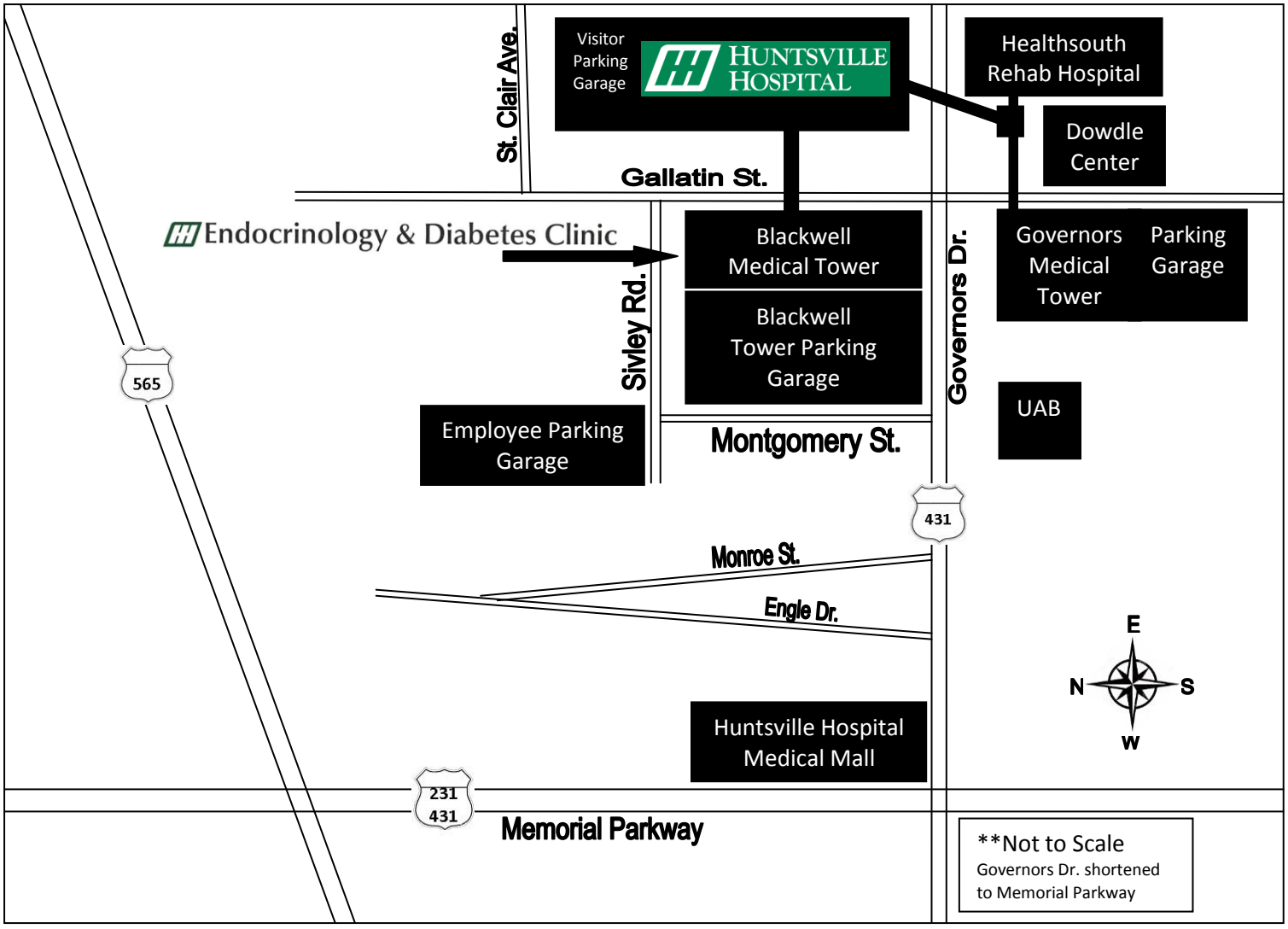
Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____

Endocrinology & Diabetes Clinic

201 Sivley Road
Suite 440
Huntsville, AL 35801
(256) 265-0780



Directions to 201 Sivley Road Suite 440 HSV, AL 35801 **Dr. Ankur Jindal**

Going South on Memorial Parkway

Exit right onto Governors Drive

Left at the Governors Drive light

Left onto Gallatin Street (traffic light)

Left onto Sivley Road (traffic light)

Left into Blackwell Medical Tower Parking Garage

**Garage does not gain you access into the building

**Please take elevators in the garage to the lobby level

Enter sliding glass doors in to Blackwell Medical Tower

Going North on Memorial Parkway

Exit right onto Governors Drive

Right onto Governors Drive

Left onto Gallatin Street (traffic light)

Left onto Sivley Road (traffic light)

Left into Blackwell Medical Tower Parking Garage

**Garage does not gain you access into the building

Please take elevators in the garage to the lobby level

Enter sliding glass doors into Blackwell Medical Tower

Once you are inside the building

Select "4" on elevator

Take a left onto the hallway

Suite 440 will be the last office on your left— Endocrinology and Diabetes Clinic Dr. Ankur Jindal