Endocrinology & Diabetes Clinic

Ankur Jindal, MBBS, MD, ECNU

Vasudha Reddy, MD

Dear patient,

Welcome to Huntsville Hospital Endocrinology & Diabetes Clinic. Thank you for trusting us with your care. Huntsville Hospital Endocrinology & Diabetes Clinic cares for patients with diabetes and other endocrine disorders. Our team is committed to providing quality care and compassionate service. We would like to take the opportunity to introduce you to our physicians and familiarize you with our practice.

Ankur Jindal, MD, is board certified in endocrinology and has earned endocrine certification in neck ultrasound and fine needle aspiration. He completed his residency at University of Pittsburgh Medical Center, Mercy Hospital and a fellowship in endocrinology and metabolism at the University of Missouri.

Vasudha Reddy, MD, is a graduate of JJM Medical College in India. She completed both her internal medicine residency and endocrinology and metabolism fellowship at the University of Buffalo in New York and is board certified in internal medicine as well as endocrinology, diabetes and metabolism.

We ask that you arrive 30 minutes prior to your appointment to allow us time 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. 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 we can offer the appointment time to another patient on our waiting list.

Please complete the enclosed forms prior to your appointment and bring them with you on your appointment date, along with your identification cards, insurance cards, medication list and your co-payments and/or deductibles. If applicable, please bring your glucometer and blood glucose logs as well.

Please feel free to visit our website (*huntsvillehospital.org/edc*) and explore the wide variety of patient education. Our physicians provide consultation services. It is important to note that while you are seeing one of our physicians, you will need to maintain a primary care provider. This will allow for seamless coordination of care and ensure that you are receiving the best care possible at all times. If you change your primary care provider, please let our staff know so we can update your records accordingly.

Thank you again for choosing Huntsville Hospital Endocrinology & Diabetes Clinic. 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.

Sincerely,

Huntsville Hospital Endocrinology & Diabetes Clinic

201 Sivley Road, Ste. 440
Huntsville, AL 35801
o: (256) 265-0780
f: (256) 265-0781

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:** _____

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

PATIENT INFORMATION

PLEASE PRINT DATE_____

Patient's Name _____ Referred By _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell Phone_____

SS# _____-_____-_____ Sex M F D.O.B._____/_____/_____

Email Address _____

Patient's Occupation _____ Employer:_____ _____

Employer's Address _____Employer's Phone ( )_____ _____

Spouse's Name _____Spouse's D.O.B. _____/_____/_____ Spouse's SS # _____-_____-_____

Spouse's Occupation _____Spouse's Employer_____ _____

Employer's Address _____ Employer's Phone ( ) _____

Notify in case of emergency _____Relationship _____

City _____ State _____ Phone ( ) _____

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

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE ( )_____

I agree that 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 collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care 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 assignment applies.

Signature _____ Date _____Time_____

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 eat 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? _____

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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 lose 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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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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Name:_____ Date of Birth:_____

Bone/Parathyroid Disease Questionnaire

1. Have you ever had kidney stones? No Yes
2. Were you ever diagnosed with any cancer? No Yes, what kind? _____

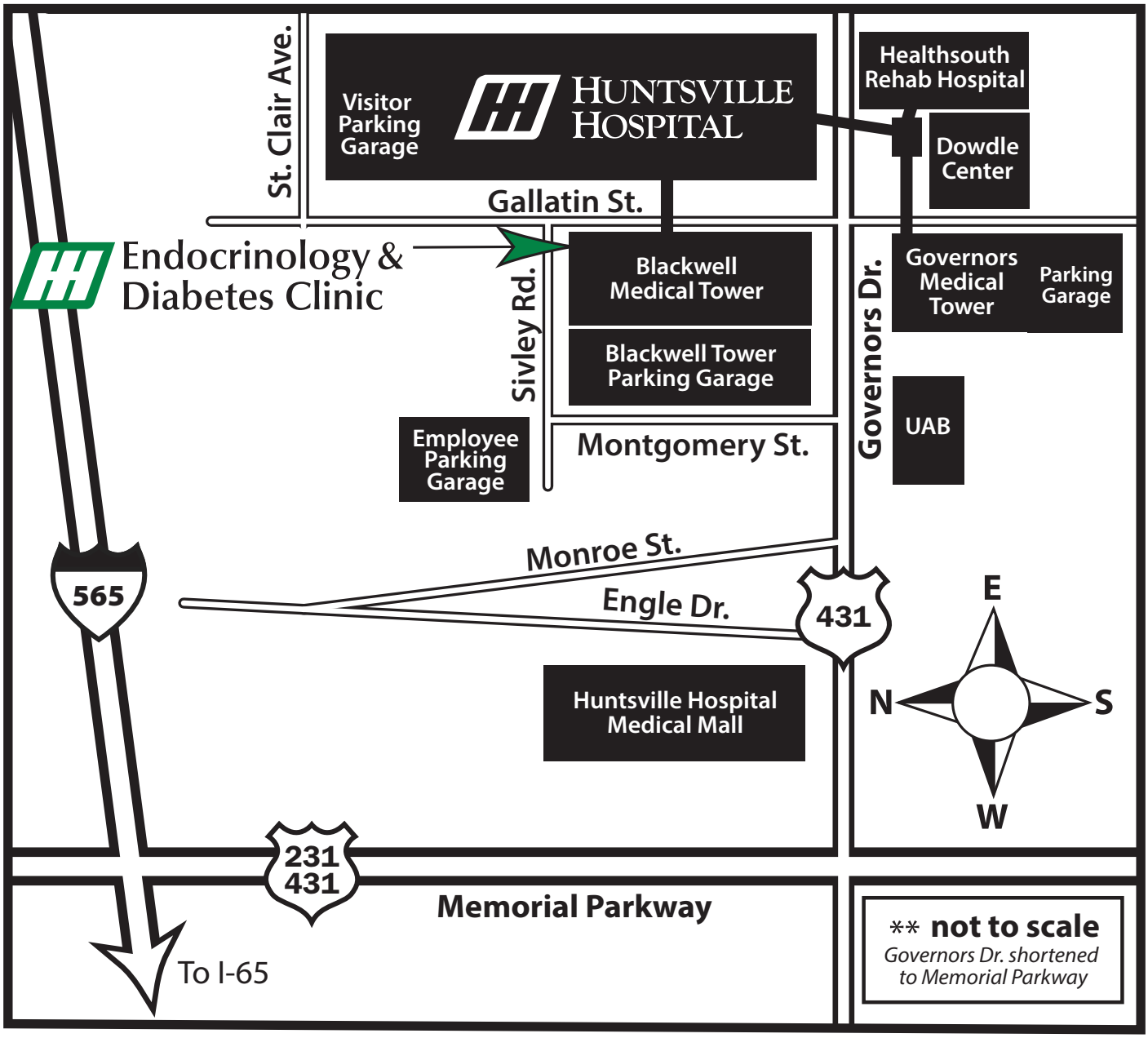
   _____
3. Please list the calcium supplements/Tums you take and the dosage_____

   _____
4. Please list the Vitamin D supplements and the dosage_____

   _____
5. Do you take calcitriol? No Yes, how much? _____
6. How many servings of dairy/milk products do you consume in a day? _____
7. Please list all bone fractures that you have sustained _____

   _____
8. When was your last bone scan/DEXA scan? _____
9. Have you ever taken any treatment for osteoporosis? No Yes, please list the medications along with the start/stop dates _____

   _____
10. Did you have any side effects with any medications for osteoporosis/weak bones? No Yes
11. Family history of high calcium? No Yes
12. Family history of parathyroid disease? No Yes
13. Have you ever had parathyroid surgery? No Yes
14. Have you ever been diagnosed with sarcoidosis? No Yes
15. Have you ever been diagnosed with lymphoma? No Yes
16. Have you ever been diagnosed with tuberculosis? No Yes
17. Do you take lithium? No Yes
18. Do you take hydrochlorothiazide (HCTZ) or chlorthalidone? No Yes



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
Please take elevators in the garage to the lobby level

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
Please take elevators in the garage to the lobby level

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 & Diabetes Clinic