Denver Endocrinology, Diabetes & Thyroid Center, PC
601 E Hampden Ave, Ste 560, Englewood, CO 80113

Patient Name: ________________________________
Date of Birth: __________________________________

ESTABLISHED PATIENT VISIT/ INFORMATION UPDATE

Please take a few moments prior to seeing your provider to update us on your health. Thank you for allowing us to provide a portion of your health care.

Describe the reason for your visit today: _______________________________________

Would you like a copy of your office note or lab results sent to anyone today? ☐Yes ☐No
If yes, who would you like to receive a copy? ____

☐ Yes! I have reviewed the attached medication list that includes prescription, over the counter and supplements and have made applicable updates

☐ I have had the following illnesses, surgeries or changes to my medical history since last visit:

1. ______________________ 3. _____________________ 5. _______________________
2. ______________________ 4. _____________________ 6. ________________________

Current smoker: ☐Yes ☐No . Number of cigarettes/cigars daily _______

Current alcohol consumption: _______ drinks per day/month

Exercise: ____days per week. Type of exercise: _____________ Duration: ________________

REVIEW: Please check any symptoms you have experienced in the past month.

- ☐ Wt gain _________lb
- ☐ Wt loss _________lb
- ☐ Fatigue
- ☐ Easy Bruising
- ☐ Excessive Sweating
- ☐ Brittle Nails
- ☐ Rash
- ☐ Skin color changes
- ☐ Dry skin
- ☐ Darkening of skin
- ☐ Stretch marks
- ☐ Peripheral Vision Loss
- ☐ Blurred Vision
- ☐ Bulging Eyes
- ☐ Headache
- ☐ Double Vision
- ☐ Hoarseness
- ☐ Snoring
- ☐ Inability to smell
- ☐ Change in dental bite
- ☐ Change in head size
- ☐ Neck pain
- ☐ Swollen glands
- ☐ Neck lump/swelling
- ☐ Difficulty breathing
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Breast enlargement
- ☐ Chest pain
- ☐ Pain with exercise
- ☐ Palpitations
- ☐ Stomach pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain with swallowing
- ☐ Loss of periods
- ☐ Irregular periods
- ☐ Painful intercourse
- ☐ Pain with urination
- ☐ Passage of stones in urine
- ☐ Bone pain
- ☐ Back pain
- ☐ Joint pain __________
- ☐ Muscle cramps
- ☐ Muscle Weakness
- ☐ Pain in Hands
- ☐ Pain in Feet
- ☐ Unexplained bone fractures
- ☐ Muscle Aches
- ☐ Change in Hand/Foot size
- ☐ Dizziness
- ☐ Fainting
- ☐ Weakness
- ☐ Lightheadedness
- ☐ Dizziness with standing
- ☐ Poor concentration
- ☐ Memory Loss
- ☐ Frequent falls
- ☐ Emotional swings
- ☐ Numbness in hands
- ☐ Numbness in feet
- ☐ Burning in hands
- ☐ Burning in feet
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Acne
- ☐ Decrease in appetite
- ☐ Increase in appetite
- ☐ Feel full before finish meal
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Heat intolerance
- ☐ Hot flashes
- ☐ Flushing of skin
- ☐ Excessive facial/body hair
- ☐ Loss of hair
- ☐ Decrease in height
- ☐ Decreased libido

Any other comments or concerns you would like to state here for the provider seeing you today:
____

Signature_______________________________________Date___________________________