



# Asheville Endocrinology Consultants

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### **Patient Questionnaire**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Eye Doctor: \_\_\_\_\_

We can now send you secure patient information on our patient portal. To participate, please provide your email address here: \_\_\_\_\_  No, I do not want electronic access.

Local Pharmacy (list city): \_\_\_\_\_

Mail Order Pharmacy: \_\_\_\_\_ Diabetes Supply Company: \_\_\_\_\_

### **Preventative Care Clinical Questions**

Do you currently smoke?  Yes  No      Have you smoked in the past?  Yes  No

### **Current Medications** (You may attach list)

Please list name, dose, and how often you take it.

Name	Dosage	Frequency of Administration
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

10. \_\_\_\_\_

11. \_\_\_\_\_

**Medication Allergies/Intolerances:**

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**Medical Problems/ Conditions/ Illnesses**

(Please circle any and all problems you have/had)

- |                     |                      |                      |                          |                  |
|---------------------|----------------------|----------------------|--------------------------|------------------|
| Type II Diabetes    | Type I Diabetes      | Unsure Type Diabetes | Gestational Diabetes     | High Cholesterol |
| Hypothyroidism      | Hyperthyroidism      | Thyroid Nodules      | Kidney Disease           | Depression       |
| Low Testosterone    | Osteoporosis         | Osteopenia           | Fatigue                  | Hypertension     |
| Atrial Fibrillation | COPD                 | Obesity              | Sleep Apnea              | Grave's Disease  |
| Diabetic Neuropathy | Erectile Dysfunction | Kidney Stones        | Coronary Artery Disease  |                  |
| Heart Attack        | Stroke               | Thyroid Cancer       | Congestive Heart Failure |                  |

Other: \_\_\_\_\_

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**Surgical History**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Family Medical History**

Please List Family Members who have/had the following conditions:

- Diabetes: \_\_\_\_\_ Early Heart Disease: \_\_\_\_\_
- Thyroid Nodules: \_\_\_\_\_ Thyroid Disorder: \_\_\_\_\_
- Breast Cancer: \_\_\_\_\_ Thyroid Cancer: \_\_\_\_\_
- Heart Attack: \_\_\_\_\_ Hypertension: \_\_\_\_\_
- Stroke: \_\_\_\_\_ Osteoporosis: \_\_\_\_\_
- Other: \_\_\_\_\_