Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite 601
Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

Welcome to Endocrinology and Diabetes of Georgia, PC

- Please be sure to **completely fill out** all paperwork pertaining to your visit. **This paperwork must be completed prior to being seen.** Please keep all paperwork **SINGLE SIDED** to scan your information into our Electronic Medical Record system.

- Please bring in your written referral or have the referring physician fax your referral if one is required with your insurance. Please refer to our insurance referrals policy in the new patient packet.

- Please call your insurance carrier and confirm that our provider, **Dr. Vijayasudha Gunna, MD**., is an In-Network Provider on your plan. All out of network visits will be billed as such. Please refer to our insurance carriers policy in the new patient packet

- We draw labs in the office through LabCorp. Some insurance may not be covered under this lab. If you are unsure which lab your insurance company requires, please call your insurance company prior to your visit. **Unless otherwise noted, all labwork will be processed and billed through Labcorp.** It is the patient's responsibility to notify the office of alternate labs required by their insurance. Please refer to our financial agreement in the new patient packet.

- Please bring any recent lab work with you or have the referring physician fax your most recent labs to our office. You will find a medical release form at the end of this packet. **These records are REQUIRED for all new patients that are being seen in our office.** Lack of records will delay your visit. Please refer to our medical records release form in the new patient packet.

- Please bring your current insurance card along with a valid driver's license or another valid, unexpired photo ID.

- Co-pays or coinsurances will be collected at the time of your visit. Endocrinology and Diabetes of GA, PC is considered a **SPECIALIST VISIT** through all insurances. We recommend that you check with your insurance company if you are unsure of the amount due. Please refer to our financial agreement in the new patient packet.

- If you need to cancel your appointment, we require a 24 hour notice. All cancellations less than 24 hours will result in a $25.00 fee. Please refer to our cancellation policy in the new patient packet.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER
WE DO NOT ACCEPT AMERICAN EXPRESS

Thank you,
Endocrinology and Diabetes of Georgia, PC

Endocrinology and Diabetes of Georgia, PC
5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

PATIENT INFORMATION

Name:_____ SEX: M F DATE OF APPT_____

ADDRESS:_____

HOME PHONE:_____CELL PHONE_____ALTERNATE PHONE_____

MOBILE PHONE CARRIER:_____**(THIS IS FOR TEXT NOTIFICATIONS FOR FUTURE APPTS ONLY)**

EMAIL ADDRESS(Please print clearly)_____

EMERGENCY CONTACT: _____PHONE:_____

PRIMARY CARE/REFERRING PHYSICIAN INFORMATION

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

ADDRESS:_____

DATE LAST SEEN:_____

REFERRING PHYSICIAN(IF DIFFERENT THAN PRIMARY)_____

ADDRESS:_____

PHONE:_____ DATE LAST SEEN:_____

PATIENT SIGNATURE_____ DATE_____

Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

INSURANCE INFORMATION

PRIMARY INSURANCE_____

ADDRESS:_____

MEMBER ID#_____

GROUP#_____

COPAY $/COINSURANCE %(IF LISTED ON CARD)_____

SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____ SUBSCRIBER SOCIAL SECURITY #_____

SECONDARY INSURANCE_____

ADDRESS:_____

MEMBER ID#_____

GROUP#_____

COPAY $/COINSURANCE %(IF LISTED ON CARD)_____

SUBSCRIBER NAME:_____

SUBSCRIBER DOB:_____ SUBSCRIBER SOCIAL SECURITY #_____

PATIENT SIGNATURE_____ DATE_____

Endocrinology and Diabetes of Georgia, PC
5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

MEDICAL HISTORY

PATIENT NAME:_____DOB:_____

REASON FOR YOUR VISIT

[Please circle appropriate choice(s)]

THYROID DIABETES PCOS

HORMONE ISSUE TESTOSTERONE NUTRITIONAL COUNSELING

SURGERY/HOSPITALIZATIONS

REASON	HOSPITAL	DATE

HEALTH MAINTENANCE

(LIST DATE/YEAR/FACILITY)

MAMMOGRAM:_____ COLONOSCOPY_____

BONE DENSITY SCAN:_____THYROID ULTRASOUND:_____

EYE EXAM:_____ FOOT EXAM:_____

THYROID BIOPSY:_____ THYROID NUCLEAR SCAN:_____

Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

MEDICATION LIST

MEDICATION NAME	DOSE/STRENGTH	DATE LAST FILLED

PHARMACY INFORMATION

LOCAL PHARMACY NAME:_____PHARMACY PHONE:_____

PHARMACY ADDRESS:_____

MAIL ORDER PHARMACY NAME:_____

PHARMACY ADDRESS:_____

PHARMACY PHONE:_____

ALLERGIES

Medication:_____ **Reaction:**_____

Medication:_____ **Reaction:**_____

Food:_____ **Reaction:**_____

PATIENT NAME:_____ **DOB:**_____

Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

HEALTH HABITS

SMOKING/CHEWING TOBACCO: YES NO YEARS:_____ PACKS/AMOUNT DAILY#_____

CAFFEINE BEVERAGES_____ AMOUNT DAILY#_____

RECREATIONAL DRUGS_____AMOUNT DAILY#_____

ALCOHOLIC BEVERAGES_____AMOUNT DAILY#_____

EXERCISE:_____ AMOUNT WEEKLY#_____

AVERAGE HOURS OF SLEEP:_____

WEIGHT LOSS OR GAIN IN LAST YEAR YES NO TOTAL AMOUNT#_____

SOCIAL HISTORY

MARRIED/ SINGLE/DIVORCED/WIDOWED/OTHER

NUMBER OF CHILDREN/AGES_____

OCCUPATION_____

INCREASED STRESS/MAJOR LIFE CHANGES:_____

_____

PATIENT NAME:_____ DOB:_____

Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

FAMILY HISTORY

(PLEASE LIST ANY KNOWN DISEASES/RELATIONSHIP TO PATIENT)

MOTHER/MATERNAL FAMILY_____

_____

_____

_____

FATHER/PATERNAL FAMILY_____

_____

_____

_____

SIBLINGS_____

_____

_____

PATIENT NAME_____ **DOB:**_____

Endocrinology and Diabetes of Georgia, PC
5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

REVIEW OF SYSTEMS

(circle all that apply)

GENERAL

Fever
Fatigue
Difficulty sleeping
Weight gain
Weight loss

PULMONARY

Cough
Emphysema
Bronchitis
Asthma
TB Skin Test

EENT

Change in vision
Color Blindness
Peripheral Vision Change
Motion Sickness
Allergies/Hay Fever
Difficulty Swallowing
Change in Voice

NEUROLOGICAL

Weakness
Stroke/Paralysis
Numbness/Tingling
Tremor
Headaches
Anxiety/Depression
Phobias
Hallucinations
Psychiatric Treatment
Vertigo

URINARY

Urination at night
Painful Urination
Urgency
Excessive Urination
Kidney Stones

MUSCULOSKELETAL

Pain in muscle/joints
Joint Swelling
Muscle Cramps
Arthritis
Back Pain

CARDIOVASCULAR

Palpitations
Chest Pain
Heart Disease
Heart Murmur

ENDOCRINE

Change in Hand Size
Change in Shoe Size
Abnormal Sweating
Excessive Thirst
Sugar In Urine
High/Low Calcium
Change in Appetite
Changes In Hair
Cold/Heat Intolerance
Head Neck Irradiation
Thyroid Disorder
Enlarged Thyroid
Changes in Breasts
Osteoporosis
Bone Fractures

SKIN

Color/Texture changes
Change in hair/nails
Rash/Itching
Easy Bruising
Acne

MALE REPRODUCTIVE

Prostate Cancer
Lack of Sexual Drive
Difficulty with Erections
Impotence
Penile Discharge
Prostatitis

GASTROINTESTINAL

Heartburn
Food/Lactose Intolerance
Nausea/Vomiting
Excessive Belching
Bloating
Hepatitis
Jaundice
Pancreatitis
Diarrhea
Constipation

PATIENT NAME:_____ **DOB:**_____

Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

DIABETES HISTORY

When was Diabetes diagnosed:_____

Which meter is used to check blood sugars:_____

How often are readings done:_____

Average fasting reading_____

Average 2hour post meal reading_____

Describe dietary habits:_____

_____

Concerns/Questions about Diabetes:_____

_____

CURRENT SYMPTOMS

(Please circle all that apply)

Excessive Urination	**Nighttime Urination**	**Low/High Blood sugar**
Slow Healing	**Excessive Thirst**	**Headaches**
Night Sweats	**Vision Issues**	**Diarrhea**
Tingling/Numbness/Burning in Hands/Feet		**Babies over 9lbs at birth**

PATIENT NAME:_____ **DOB:**_____

Endocrinology and Diabetes of Georgia, PC
5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

THYROID HISTORY

When was thyroid condition diagnosed_____

Family History of Thyroid Conditions

(Please circle all that apply)

HYPOTHYROIDISM	**HYPERTHYROIDISM**	**THYROID NODULEs**
THYROID CANCER	**GOITER**	**THYROID SURGERY**
GRAVES' DISEASE		

CURRENT SYMPTOMS

(Please circle all that apply)

Difficulty Swallowing	**Hoarseness**	**Change in Nail/Hair**
Weight Issues	**Racing Heart/Palpitations**	**Change in Bowels**
Fatigue	**Depression**	**Concentration Issues**
Change in Menstrual Cycle	**Protruding Eyes**	**Vision Issues**
Hot or Cold Body Temperature		

PATIENT NAME:_____ DOB:_____

Endocrinology and
Diabetes of Georgia, PC

5400 Laurel Springs Pkwy, Suite
601 Suwanee, GA. 30024
Phone : 770 754 1600
Fax : 770 754 1605

MENSTRUAL HISTORY

(IF APPLICABLE)

MENSTRUAL CYCLE

Cycle Frequency:_____ Duration of cycle:_____

Flow: Heavy Normal Light Spotting Last Pap Smear:_____

Other associated symptoms during cycle:_____

Date of last cycle:_____ Age cycle began:_____

Number of missed cycles in the last year:_____

Hysterectomy: YES NO Date_____ Ovaries removed: YES NO Date_____

Tubal Ligation YES NO Date_____

PREGNANCIES

Pregnancies#:_____ Live births#:_____ Weeks at Delivery:_____

Abortions#:_____ Miscarriages#_____

Premature births#:_____ Weeks at Delivery:_____

Complications of pregnancies/deliveries:_____

_____