**MEDSTAR WASHINGTON HOSPITAL CENTER**
**SECTION OF ENDOCRINE SURGERY**
*106 Irving Street, NW*
*Physician Office Building Suite # 124.*
*Washington, DC 20010*
*Phone 202-877-5611/3158. Fax 202-877-3108*

**MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL**
**SECTION OF ENDOCRINE SURGERY**
*3800 Reservoir road NW*
*Pasquerilla Health Center, 4th Floor*
*Washington, DC 20007*
*Phone 202-877-5611/3158 Fax 202-877-3108*

Dear ____________________________:

Thank you for choosing **Medstar Washington Hospital Center and MedStar Georgetown University Hospital Section of Endocrine Surgery** to meet your surgical needs. You have a consultation appointment on
(Date) _____________ at (Time) _____________ with (Doctor) ____________________________

## PLEASE BE SURE TO ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT.

**If you are unable to make your appointment, please kindly give us a 24-hour notice.**

Your appointment is at the following office

- Medstar Washington Hospital Center
  106 Irving Street, NW
  Physicians' Office Bldng-South Suite 124
  Washington, DC 20010
- Mitchellville Plaza
  12158 Central Avenue Suite 700
  Mitchellville, MD 20721
- MedStar Health at Chevy Chase
  5454 Wisconsin Avenue Suite 1100
  Chevy Chase, MD 20815
- MedStar Health at McLean
  6862 Elm street, Suite 800A
  McLean, VA 22101
- MedStar Georgetown University Hospital
  3800 Reservoir road NW,
  Pasquerilla Health Center, 4th floor
  Washington, D.C. 20007
- Lafayette Center
  1133 21st St. NW
  Building 2, 6th Floor
  Washington, DC 20036
- MedStar Multispecialty Services
  7501 Surratts road, Suite 305
  Clinton, MD 20735

Enclosed you will find your patient intake form. **Please fill out the form and fax back to the office PRIOR to your scheduled visit.** Please fax to **1(888)680-5519 or (202)877-3108.** If you are unable to fax your forms to the office, please bring the completed forms with you to your appointment. If you have any questions, please contact the office at (202)877-2506.

Jennifer Rosen M.D., F.A.C.S.
Erin Felger, M.D., F.A.C.S.
Nancy Carroll, M.D.
Victoria Lai, M.D. F.A.C.S.

It is **VERY** important to bring all your records and images on CD or have your physician fax them over.

**For THYROID Issues - Please bring:**

- **Thyroid Scan and/or Ultrasound Report (***pick up your actual films /disk from the location you took the test***)**
- **Fine Needle Aspiration Biopsy Report (FNA)**
- **Thyroid Blood Function Testing (T3, T4, TSH, etc.) and any other related labwork**
- **Any previous operative reports and pathology**

**For PARTHYROID Issues - Please bring:**

- **Parathyroid Scan (***Please pick up your actual films/disk from location you took test***)**
- **Calcium and Intact PTH levels; 24-hour urine; and Bone Density Scan and any other related labwork**
- **If done, parathyroid scan, Ultrasound, DEXA (bone density scan), MIBI scan and any other related imaging**
- **Any previous operative reports and pathology**

**For ADRENAL Issues Only-Please bring:**

- **CT of Abdomen (***Please pick up your actual films/disk from the location you took the test***)**
- **Lab work**
- **If done, CT, MRI of abdomen**
- **If done, adrenal vein sampling result**

**Please remember to bring your Photo I.D., Insurance Card, Referral forms, and co-pay if needed.**

If additional information is needed please feel free to contact the office at the number below.
Thank you in advance for your cooperation. We look forward to your visit.

Endocrine Surgery Staff
(202)877-3158

MedStar Washington Hospital Center

**Department of Endocrine Surgery**
**Patient Intake Form**

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## PATIENT INFORMATION

Patient Name: Last First Middle

| Date of Birth: | Age: | Gender: | SSN: |
|---|---|---|---|

Home Address (Street Address or Unit Code, City, State, Zip Code):

| Home Phone: | Mobile: | Work/Other Phone: |
|---|---|---|

Marital Status (Circle One): Married Single Divorced Separated Widowed Partner/Other

Employment Status: Occupation:
(If retired, retired date:)

Employer Name and Address:

## EMERGENCY CONTACT

**Contact 1**
**Name:**
Home Address:
Phone:
Relationship to patient:

**Contact 2**
**Name:**
Home Address:
Phone:
Relationship to Patient:

## INSURANCE INFORMATION

**Primary Insurance**
Policy Number:
Group Number:
Subscriber's Name:
Subscriber's Gender:
Subscriber's Date of Birth:
Subscriber's Relationship to Patient:

**Secondary Insurance**
Policy Number
Group Number
Subscriber's Name
Subscriber's Gender
Subscriber's Date of Birth
Subscriber's Relationship to Patient

## PHYSICIAN INFORMATION

**Primary Care Provider Information**
**Name:**
Address (City, State, Zip Code):
Phone:
Fax:

**Referring Provider**
**Name:**
Street Address:
City:
State/Zip Code:
Phone:
Fax:

**Cardiologist**
**Name:**
Street Address:
City:
State/Zip Code:
Phone:
Fax:

## PREFERRED PHARMACY INFORMATION

**Pharmacy name:**
Address (City, State, Zip Code):
Pharmacy Phone: Pharmacy Fax:

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**MEDICAL HISTORY:** Height: Weight:

What are you being seen for today/What is your reason for visit? ____________________________________________

How was this found in the first place?____________________________________________________________

What imaging have you had so far?______________________________________________________________

**ARE YOU HAVING ANY SYMPTOMS?** *(Please check or circle symptoms that you have or have had in the past)*

| | | | |
|---|---|---|---|
| **GENERAL**<br>Fatigue<br>Fever<br>Weight loss (over 10 lbs in 6 months)<br>Weight gain (over 10 lbs in 6 months)<br>Night sweats<br>Insomnia | **RESPIRATORY**<br>Cough<br>Wheezing<br>Shortness of breath | **MUSCULOSKELETAL**<br>Joint pain<br>Joint swelling<br>Bone fracture<br>Muscle pain<br>Back pain<br>Height loss | **ENDOCRINE**<br>Loss of hair<br>Heat intolerance<br>Cold intolerance<br>Difficulty moving neck<br>Difficulty opening mouth |
| **EYES**<br>Glasses/Contacts<br>Eye pain<br>Blurry vision<br>Double Vision | **GASTROINTESTINAL**<br>Poor appetite<br>Heartburn/Reflux<br>Yellow skin<br>Abdominal pain<br>Diarrhea<br>Constipation<br>Difficulty swallowing | **CARDIOVASCULAR**<br>Rapid heartbeat<br>Chest pain<br>Dizziness<br>Shortness of breath<br>Irregular heartbeat | **NEUROLOGICAL**<br>Loss of strength<br>Numbness<br>Headaches<br>Tremors |
| **EAR, NOSE, THROAT**<br>Difficulty hearing<br>Hoarseness<br>Sore throat<br>Difficulty swallowing | **GENITOURINARY**<br>Kidney stones<br>Increased urination<br>Increased fluid intake<br>Blood in urine | **HEMATOLOGIC/LYMPH**<br>Easy bruising<br>Enlarged glands<br>History of blood clots | **OTHER:** |
| **ALLERGIC/IMMUNOLOGICAL**<br>Hives<br>Eczema<br>Hay fever | **SKIN**<br>Rashes/Sores<br>Dryness | **PSYCHOLOGICAL**<br>Depression<br>Anxiety | |

**DO YOU HAVE ANY MEDICAL CONDITIONS?** *(Please check or circle conditions you have or had in past)*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | AIDS | | Epilepsy | | HIV positive | | Seizures |
| | Anemia | | GERD | | Hypertension | | Sleep apnea |
| | Asthma | | Goiter | | Kidney disease | | Stomach ulcers |
| | Bleeding disorders | | Heart attack | | Liver disease | | Stroke |
| | Chronic bronchitis | | Heart disease | | Multiple Sclerosis | | Thyroid problems |
| | Diabetes (Last A1C) | | Hepatitis | | Pacemaker | | Cancer (specify) |
| | Deep vein thrombosis | | Hiatal hernia | | Pulmonary embolism | | |
| | Emphysema | | Herniated disc | | Pneumonia | | Other (specify) |

**HAVE YOU HAD SURGERY IN THE PAST?** *(If yes, please list and describe)*

| Year | Surgical Procedure | Year | Surgical Procedure |
|---|---|---|---|
| | | | |
| | | | |

Have you had an adverse reaction to anesthesia? *(If yes, please explain)*

Family history of adverse reaction to anesthesia? *(If yes, please explain)*

*Patient Name:* ____________________________________________ *Date of Birth:* _____________

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## MEDICATION AND FOOD ALLERGIES *(Please list all known allergies, drug, food etc)*

| Substance | Reaction | Substance | Reaction | Substance | Reaction |
|---|---|---|---|---|---|
| | | | | Latex | YES/NO |
| | | | | Iodine | YES/NO |
| | | | | Shellfish | YES/NO |

## MEDICATIONS *(Please list all medications you take, prescription and non-prescription and dosage)*

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## SOCIAL HISTORY: *(Please tell us about yourself)*

What is your occupation?
If retired, former occupation

| Are you pregnant? | Are you trying to conceive? | Last Menstrual Period: |
|---|---|---|

Where were you born?
If born outside of the U.S. where were you born?

**Tobacco use: Do you smoke?** YES/NO
If yes, for how long have you smoked? _______________ How many packs per day do you smoke? ________________
If no, have you smoked in the past? _________________ When did you stop? __________________________________

**Alcohol use: Do you drink alcohol?** YES/NO Briefly describe how much you drink:
Former/ Year quit/how much did you drink?

**Any current or significant past drug use?** If yes, please briefly describe.

## FAMILY HISTORY: *(Please tell us about your family)*

Is your father alive? YES/NO If deceased, age and cause of death:
Did he have any medical problems?

Is your mother alive? YES/NO If deceased, age and cause of death
Did she have any medical problems?

Do you have any siblings? If yes, how many? Any medical problems?

Do you have any children or grandchildren? If yes, how many and ages? Any medical problems?

| **Family Medical Issues:** | Mother/Father/Brother/Sister/Other (Specify):_________________________ |
|---|---|
| Thyroid disease/Adrenal Disease/Other Endocrine Disease: | |
| High calcium/kidney stones: | |
| Hypertension: | |
| Stomach ulcers: | |
| Cancer (specify): | |
| Bleeding issues/Other: | |

*Patient Name:* __________________________________________ *Date of Birth:* _____________

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Additional notes:

*I have reviewed the above information and confirm it is accurate, to the best of my knowledge.*

Signature__________________________________ Date ________________________

*Patient Name:* ____________________________________________ *Date of Birth:* _____________