Draelos Metabolic Center
1600 Medical Center Drive, Edmond, OK 73034
Tel 405.330.2362 Fax 405.330.2363
info@draelosmetabolic.com
draelosmetabolic.com

Dear Patient,

Welcome to Draelos Metabolic Center! Thank you for the opportunity to care for your endocrine and bariatric health needs. Your initial appointment has been scheduled with Matthew T. Draelos, MD, a board certified endocrinologist, and Fellow of the American College of Endocrinology.

Dr. Draelos' primary purpose is to provide you with the best medical care possible. The Draelos Metabolic Center team is dedicated to caring for your diabetes, thyroid, pituitary, adrenal, lipid (cholesterol), high blood pressure, osteoporosis, testosterone, hormone imbalance, nutrition, and weight management concerns.

Draelos Metabolic Center offers on-site moderately complex and CLIA waived lab tests, diabetic retinopathy screening, continuous glucose monitoring, thyroid ultrasound and biopsy, electrocardiogram, indirect calorimetry, bioimpedance analysis, and insulin pump training. We also carry specialized medical foods and supplements.

The team at Draelos Metabolic Center does ask you to consult with your primary care provider to handle your other health needs and illnesses of a general nature, such as strep throat, ear or sinus infections, allergies, injuries, or other such medical issues unrelated to the endocrine system.

In the event that you require hospitalization, the Hospitalist (specialist in inpatient care at the hospital) at the hospital of your choice, will manage your care in coordination with your primary care provider. The providers at Draelos Metabolic Center will be available by telephone to assist your primary care provider should the need arise.

With your cooperation, the team at Draelos Metabolic Center will ensure your time spent with us, from check-in to check-out, will be productive and beneficial. We are looking forward to working hand-in-hand with you!

Sincerely,

The Draelos Metabolic Team

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PATIENT INFORMATION

Name: (First)_____(MI)_____(Last)_____

Birth Date:_____SSN:_____Gender:_____

Mailing Address: (Street/PO Box):_____City:_____

State: _____Zip:_____

Phone #s: (Cell)_____(Home) _____(Work)_____

E-mail Address: _____

Referring Doctor:_____Phone #:_____

If self-referred, how did you hear about us? **FRIEND** **SOCIAL MEDIA** **OTHER**:_____

Primary Care Doctor:_____Phone #:_____

Employer:_____Phone #:_____

PRIMARY INSURANCE INFORMATION

Company Name:_____ID#:_____Group #:_____

Claims Address (Listed on Card):_____

Policy Holder's Name:_____Birth Date:_____

Policy Holder's SSN:_____Relationship to Patient:_____Gender:_____

SECONDARY INSURANCE INFORMATION

Company Name:_____ID#:_____Group #:_____

Claims Address (Listed on Card):_____

Policy Holder's Name:_____Birth Date:_____

Policy Holder's SSN:_____Relationship to Patient:_____Gender:_____

GUARANTOR (IF OTHER THAN PATIENT)

Name: (First)_____(MI)_____(Last)_____

Mailing Address: (Street/PO Box):_____

_____City:_____State:_____Zip:_____

Phone #s: (Cell)_____(Home) _____(Work)_____

Guarantor SSN:_____Birth Date:_____Relationship to Patient:_____

EMERGENCY CONTACT

Name:_____Relationship to Patient:_____Phone #:_____

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MEDICATIONS

Patient Name:_____Birth Date:_____Today's Date:_____

In order for our clinic to provide you with the best care, please provide a CURRENT LIST of your prescription medications (INCLUDING INSULIN), non-prescription medications, and any supplements.

Pharmacy Name:_____Phone #:_____

MEDICATION & STRENGTH	DOSAGE/UNITS	TIMES TAKEN (IN 24 HR)	PRESCRIBER

Patients are responsible for notating any changes in their current medication(s). Also, they need to inform the medical staff regarding any prescription refills that are needed at the time of the appointment.

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MEDICAL HISTORY (Page 1)

Patient Name:_____Birth Date:_____Today's Date:_____

REVIEW OF SYSTEMS

Constitution
- Chills
- Fatigue
- Unexpected Weight Change

Head, Ears, Nose, Throat
- Mouth sores
- Trouble Swallowing
- Voice Change

Eyes
- Eye Pain
- Visual Disturbance

Respiratory
- Apnea
- Chest Tightness
- Cough
- Shortness of Breath

Cardio
- Chest pain
- Leg Swelling
- Palpitations

Gastrointestinal (GI)
- Abdominal Pain
- Diarrhea
- Nausea
- Vomiting

Endocrine
- Cold Intolerance
- Heat Intolerance
- Plydipsia (abnormal thirst
- Polyphagia (abnormal hunger
- Polyuria (excess urination)

Genitourinary (GU)
- Difficulty Urinating
- Dysuria (Discomfort, pain, burning when urinating)
- Urgency (Immediate unstoppable urge to urinate)
- Hematuria (Blood in urine)

Muscle
- Arhralgias (Join Pain)
- Joint Swelling
- Myalgias (Muscle pain)

Skin
- Color Change
- Pallor (Pale Skin)
- Rash
- Wound

Neurological
- Dizziness
- Numbness

Phychological
- Nervous/Anxious
- Confusion

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MEDICAL HISTORY (Continued- Page 2)

Patient Name:_____Birth Date:_____Today's Date:_____

PATIENT MEDICAL HISTORY

- o Unremarkable
- o Diabetes, Type I Yr. Diagnosed:_
- o Diabetes, Type II Yr. Diagnosed:_
- o Diabetic Neuropathy
- o Diabetic Eye Disease
- o Diabetic Ketoacidosis
- o Kidney Function
- o Gastroparesis
- o PCOS
- o Gestational Diabetes
- o Hyperthyroid
- o Hypothyroid
- o Thyroid Nodule
- o Hyperparathyroid
- o Hypercalcemia (elevated calcium)
- o Hypogonadism
- o Osteoporosis
- o Osteopenia
- o Fractures, spontaneous
- o Panhypopituitary
- o Sleep Apnea
- o Cushings Disease
- o Addison's Disease
- o Cancer, Breast Yr. Diagnosed:_
- o Cancer, Colon Yr. Diagnosed:_
- o Cancer, Prostate Yr. Diagnosed:_
- o Cancer, Thyroid Yr. Diagnosed:_
- o Cancer, Other:_ Yr. Diagnosed:_
- o Heart Attack
- o Heart Disease
- o Coronary Artery Disease
- o CongestiveHeart Failure
- o Heart Murmur
- o Atrial Fibrillation (A-Fib)
- o Irregular Heart Rate
- o Rapid Heart Rate
- o Deep Vein Thrombosis
- o Stroke
- o Pacemaker
- o High Cholesterol
- o Hypertension
- o AIDS/HIV+
- o Alcohol Dependency
- o Anorexia/Bulemia
- o Emphysema
- o Epilepsy
- o Arthritis
- o Asthma/COPD
- o Bleeding Disorder
- o Cataracts
- o Chemical Dependency
- o Depression
- o Anxiety
- o Psychiatric Care
- o Suicide Attempt
- o Glaucoma
- o Gout
- o Hepatitis B/C
- o Kidney Disease
- o Kidney Dialysis
- o Liver Disease
- o Headaches
- o Miscarriage
- o Multiple Sclerosis
- o Ulcers foot/leg
- o Blindness, Full/Partial
- o Dementia
- o Alzheimers
- o Crohns Disease
- o Ulcerative Colitis
- o GERD/Acid Reflux
- o Stomach Ulcers
- o Pancreatitis
- o Kidney Stones
- o Enlarged Prostate
- o Pregnancy to Term
- o Fathered a Child
- o Others, not listed:
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____

ALLERGIES

- o Soy
- o Adhesive
- o Latex
- o Medication:_____
- o Medication:_____
- o Medication:_____

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MEDICAL HISTORY (Continued- Page 3)

Patient Name:_____Birth Date:_____Today's Date:_____

PATIENT SURGICAL HISTORY

- o Unremarkable
- o Abdominal Surgery
- o Type:_____
- o Amputation
- o Specify:_____
- o Appendectomy
- o Back Surgery
- o Cardiac Bypass
- o Carotid Endarterectomy
- o Carpal Tunnel
- o Cataract Extraction
- o Cholecystectomy
- o (Gallbladder removal)
- o Colon Resection
- o Craniotomy (Brain)
- o Gastric Bypass or Band
- o Hemorrhoidectomy
- o Hysterectomy, complete
- o Hysterectomy, partial
- o Heart Valve Replacement
- o Kidney Removal, no transplant
- o Kidney Transplant
- o Pacemaker
- o Parathyroidectomy
- o Pneumonectomy
- o Prostatectomy
- o Orthopedic Surgery
- o Tonsillectomy
- o Tunneled Dialysis Cath.
- o Urinary Incontinence
- o Vertebroplasty
- o Thyroid Surgery
- o C-Section
- o Other:
- o _____
- o _____
- o _____
- o _____
- o _____

DIAGNOSTIC TESTING	Date
CT Scan (last 3 months)	_____
MRI Brain	_____
Sleep Study	_____
Eye Exam	_____
Dental Exam	_____
EKG	_____
Flu Vaccination	_____
Pneumonia Vacc.	_____
Last Bone Density	_____
_____	_____
_____	_____
_____	_____

Eye Doctor:_____
Dentist: _____
Cardiologist:_____

Primary Care:_____
Physician:_____
Physician:_____
Physician:_____

HOSPITALIZATIONS

Year	Reason	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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MEDICAL HISTORY (Continued- Page 4)

Patient Name:_____Birth Date:_____Today's Date:_____

PROCEDURES

- ○ Cardiac Heart Catheterization
- ○ Diabetes Retina-Laser
- ○ Interventional Pain Procedure
- ○ Thyroid Ablation
- ○ Other
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____
- ○ _____

SOCIAL HISTORY

- ○ Caffeine ≥ 2/day
- ○ Exercise, None
- ○ Exercise, Light 1-2x/week
- ○ Exercise, Heavy ≥ 3x/week
- ○ Illicit Drug Use
- ○ Tobacco, Former
- ○ Tobacco, Current
- ○ Tobacco, Never
- ○ Alcohol, ≥ 2 drinks/day
- ○ Single
- ○ Married
- ○ Divorced
- ○ Number of Children:_____
- ○ Occupation:_____

FAMILY HISTORY

Relationship Legend: **F** = Father; **M** = Mother; **SI** = Sister; **B** = Brother; **D** = Daughter; **SO** = Son

	RELATIONSHIP					
	F	**M**	**SI**	**B**	**D**	**SO**
History Unknown	○	○	○	○	○	○
Thyroid Disease	○	○	○	○	○	○
Obesity	○	○	○	○	○	○
Diabetes, Type I	○	○	○	○	○	○
Diabetes, Type II	○	○	○	○	○	○
Diabetes, Gestational	○	○	○	○	○	○
Pituitary Tumors	○	○	○	○	○	○
Osteoporosis	○	○	○	○	○	○
Cancer, Breast	○	○	○	○	○	○
Cancer, Ovarian	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○

	RELATIONSHIP					
	F	**M**	**SI**	**B**	**D**	**SO**
High Cholesterol	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Kidney Stones	○	○	○	○	○	○
Lupus/SLE	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○
Elevated Calcium	○	○	○	○	○	○
Early Heart Disease	○	○	○	○	○	○
○ Male ≤ 55	○	○	○	○	○	○
○ Female ≤ 65	○	○	○	○	○	○
Other:_____	○	○	○	○	○	○
_____	○	○	○	○	○	○
_____	○	○	○	○	○	○

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DRAELOS METABOLIC CENTER
HIPAA Consent Form

This consent form must be completed and signed prior to receiving medical treatment from our office. Please return this form to the reception upon completion.

I understand that as part of my medical care, this office originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- a basis for planning my care and treatment
- a means for communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- and as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

By Oklahoma law we are required to notify you…**that the information authorized for release may include records which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).**

Other than myself, my **spouse,** or others previously identified in the Privacy Notice, this office has permission to use and disclose information regarding my medical care to the following specific person(s):

_____

This agreement to release future information shall remain in force until such time as I revoke it in writing.

I understand and have been provided with a **Patient Privacy Notice** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that this office reserves the right to change the notice and practices, but that prior to implementation, a copy of any revised notice will be provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that my doctor is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action.

_____

Patient's Full Name

_____ _____

Signature of Patient or Legal Representative if minor | Printed Name and Relationship to Patient

_____

Today's Date (Effective date of notice)

****Note:** If you wish to have a copy of this consent form please notify the receptionist.