SUBURBAN ENDOCRINOLOGY ASSOCIATES, P.C.
MARILYN RYAN, M.D., F.A.C.E.
SHALINI VIJAYKUMAR, M.D.
JAMIE DILLINGER, C.R.N.P.

21 Industrial Blvd., Suite 101
Paoli, PA 19301

Telephone: (610) 251-0300
Fax: (610) 251-0304

Welcome to Suburban Endocrinology Associates.

Upon your initial visit with us, please bring your insurance card(s) and photo ID so that we may scan them into your EMR.

It is imperative that you bring any test results, written reports of any testing, i.e. ultrasounds, scans, etc., that you may have had done in the past in reference to your endocrine problem. If you are being seen for diabetes, you should bring two weeks of blood sugar testing results with you to the appointment.

If you are an HMO patient requiring a referral, please make sure that your referral is available at the time of your visit. You will not be seen without a valid referral. For all insurances, co-pays are due at the time of your visit. We accept cash, checks, and major credit cards.

Please call us with any questions.

Thank you,

Suburban Endocrinology Associates

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Marilyn Ryan, M.D., F.A.C.E
Shalini Vijaykumar, M.D.
Jamie Dillinger, C.R.N.P.

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PLEASE PRINT CLEARLY

Name:_____ Age:_____ Date of Birth_____/____/_____
Address:_____Patient's SS#_____
City:_____State:_____Zip Code:_____
Phone: Home_____/_____/_____ Cell_____/_____/____ Work_____/_____/_____

Patient Portal: Email-address_____

Primary Insurance Company_____

Subscriber's Name:_____

Relationship to Patient_____/ Insured's DOB_____

Member's ID#_____/ Group #_____

Secondary Insurance Company_____

Subscriber's Name:_____

Relationship to Patient_____/ Insured's DOB_____

Member's ID#_____/ Group #_____

Referring Physician and / or Family Physician_____
Phone #_____/_____/_____ Fax# _____/_____/_____
Address:_____
Pharmacy:_____Phone #_____/_____/_____
Address _____

I AUTHORIZE RELEASE OF INFORMATION TO ALL OF MY INSURANCE COMPANIES
I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR
I UNDERSTAND THAT I AM RESPONSIBLE FOR MY ACCOUNT WITH SUBURBAN END ASSOC, PC.
I permit a copy of the authorization to be used in place of the original
I HAVE READ THE ABOVE AND UNDERSTAND ALL STATEMENTS ABOVE.

Please sign:_____ Date:_____/_____/_____

Revised October 7, 2015

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PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Please take a few minutes to give us the following information. It will assist us in getting to know you better.

Reason for your visit today: _____

Please circle if you have now or have ever had any of the following:

Cancer	Rheumatic Fever	Asthma	Goiter
Kidney Stones	Heart Problems	Cataracts	Diabetes
Epilepsy	Nervous Breakdown	Stomach Ulcers	Stroke
Bad Headaches	High Blood Pressure	High Cholesterol	Colitis
Pneumonia	Kidney Disease	Anemia	Past Fractures
Pituitary Tumors	Osteoporosis	Childhood Neck Irradiations	

Other Significant Illness/Injuries _____

Previous Operations: Year:

_____ _____

_____ _____

_____ _____

Allergies _____

FAMILY HEALTH PROBLEMS

Father _____ Paternal Grandmother _____

Mother _____ Paternal Grandfather _____

Your Children _____ Maternal Grandmother _____

Brother(s) _____ Maternal Grandfather _____

Sister(s) _____ Aunt(s) _____

_____ Uncle(s) _____

Do other family members not listed above have any of the following? (Circle any that apply.)

Diabetes	Thyroid Disease	High Cholesterol	Kidney Stones
Osteoporosis	Heart Disease	Hypertension	Strokes
Hormone Problem			

Married ____ Divorced _____ Widowed _____ Single _____

Whom do you live with? _____

Children _____

Occupation _____ Hours _____Retired? _____

Smoke Y / N Amount _____ Date Quit _____ Amt/Years smoked _____

Alcohol Use Y / N Frequency _____

Drug Use Y / N Quit _____ Type _____

Exercise Y / N Type _____Frequency _____

Previous Prescribed Diet Y / N Type _____

Time of Meals and Daily Schedule:

Arise _____ Lunch _____ Supper _____ Snacks _____ Bedtime _____

Medications:

Name of Medication	Strength	Directions

Reviewed with Patient: Signature _____ Date _____

GENERAL:
0 Recent weight gain
0 Recent weight loss
0 Fatigue
0 Weakness
0 Trouble sleeping
0 Excessive thirst

NERVOUS SYSTEM:
0 Headaches
0 Dizzy / Lightheaded
0 Shaking
0 Fainting
0 Loss of consciousness
0 Sensitivity / pain in hands or feet
0 Memory loss

EYES:
0 Pain
0 Redness
0 Loss of vision
0 Double / blurred vision
0 Dryness
0 Change in appearance of eyes

MENTAL:
0 Anxiety
0 Mood swings
0 Trouble concentrating

NOSE:
0 Nosebleeds
0 Loss of smell

MOUTH:
0 Bleeding gums
0 Sores in mouth
0 Loss of taste
0 Dryness

HEART AND LUNGS:
0 Chest discomfort
0 Sudden changes in heart beat
0 Shortness of breath
0 Difficulty breathing at night
0 Swollen legs and feet
0 Rapid heart beat
0 Heart murmurs
0 Cough
0 Coughing of blood
0 Wheezing
0 Night sweats

STOMACH AND INTESTINES:
0 Nausea
0 Vomiting
0 Stomach pains
0 Increasing constipation
0 Yellow jaundice
0 Blood in stool
0 Heartburn
0 Appetite changes
0 Early fullness when eating

KIDNEY/BLADDER/URINE:
0 Difficult urination
0 Pain or burning on urination
0 Blood in urine
0 Cloudy urine
0 Discharge from penis/vagina
0 Frequent urination
0 Urination during the night
0 Vaginal dryness
0 Sexual difficulties
0 Prostate trouble

BLOOD:
0 Bleeding tendency

OTHER :
_____
_____
_____

SKIN:
0 Easy bruising
0 Redness / rash
0 Sun sensitivity
0 Breast discharge
0 Enlarged breast (Males)
0 Nodules / bumps
0 Hair loss
0 Excessive hair
0 Stretch marks

MUSCLES/JOINTS/BONES:
0 Muscle weakness
0 Muscle tenderness
0 Muscle cramps
0 Muscle spasms

THROAT:
0 Frequent sore throats
0 Hoarseness
0 Difficulty swallowing

NECK:
0 Swollen glands
0 Tender glands
0 Enlarged thyroid
0 Neck lumps

MENSTRUAL:
0 Not applicable
Age periods began_____
0 Periods regular
0 Periods irregular
0 PMS
Date last PAP _____
Date last mammogram
_____
Date menopause
_____
0 Bleeding after menopause