Endocrinology & Diabetes Clinic

Steven Cowart, MD
Ankur Jindal, MBBS, MD, ECNU
Bobby Johnson, MD
Vasudha Reddy, MD
Joshua Tate, MD (401 Lowell Drive)

Dear Patient,

Welcome to Huntsville Hospital Endocrinology & Diabetes Clinic. Thank you for trusting us with your care. Our team is committed to providing quality care and compassionate service. We would like to take the opportunity to introduce you to our physicians and familiarize you with our practice.

Our clinic makes every effort possible to see each patient on time. We value and respect your time. As such, we do ask that you ARRIVE 30 MINUTES prior to your appointment. This will allow us to gather the appropriate paperwork and information necessary to provide the quality care you expect and deserve. If you are running late, please call (256) 265-0780. We are happy to assist you in rescheduling your appointment to a time that is more convenient for you. If you need to cancel your appointment, please provide us with a 24 hour notice so we can offer the appointment time to another patient.

While you are seeing one of our specialists, you will need to maintain a primary care physician. This will allow for seamless coordination of care and ensure that you are receiving the best care possible at all times. If you change your primary care physician, please let our staff know so we can update your records.

Thank you again for choosing Huntsville Hospital Endocrinology & Diabetes Clinic. We appreciate the faith and trust you are placing in us. We will do our best to ensure that you receive the quality care you expect and deserve. Please do not hesitate to call (256) 265-0780 with any questions or concerns. We are always here to serve and support you.

Sincerely,

HH Endocrinology & Diabetes Clinic

401 Lowell Drive, Ste. 14
Huntsville, AL 35801
o: (256) 265-7660
f: (256) 265-7661

201 Sivley Road, Ste. 440
Huntsville, AL 35801
o: (256) 265-0780
f: (256) 265-0781

Appointment Information:

Physician: _____

Day: _____ Date: _____

Arrival Time: _____ Appointment Time: _____

**Please bring your glucometer and blood glucose logs if applicable.*

Endocrinology & Diabetes Clinic

About Our Physicians

Dr. Ankur Jindal is board certified in endocrinology, diabetes and metabolism. He has earned endocrine certification in neck ultrasound and fine needle aspiration. He also specializes in management of thyroid disease and thyroid cancer. He completed his residency at University of Pittsburgh Medical Center Mercy Hospital in Pittsburgh, Pa., followed by a fellowship in endocrinology and metabolism at the University of Missouri.

Dr. Vasudha Reddy is a graduate of JJM Medical College in India. She completed both her internal medicine residency and endocrinology and metabolism fellowship at the University of Buffalo in New York. She is board certified in endocrinology and diabetes as well as internal medicine and obesity medicine.

Dr. Steven Cowart is board certified in internal medicine and endocrinology. He completed his residency in internal medicine and fellowship in endocrinology and metabolism at the Medical College of Georgia.

Dr. Bobby Johnson has been practicing endocrinology since 1985. He was initially on the faculty of UAB School of Medicine in the division of endocrinology at Birmingham. He moved to Huntsville in 1990 to join the faculty of UAH School of Medicine and was the Chief of Endocrinology. He has been in private practice since 1998 and joined Huntsville Hospital Endocrinology & Diabetes Clinic in 2022.

Dr. Joshua Tate is board certified in endocrinology, diabetes and metabolism and internal medicine. He specializes in the management of thyroid disease and thyroid cancer. He is a graduate of the University of Alabama School of Medicine. He completed his Internal Medicine residency at Keesler Medical Center in Biloxi, MS and his endocrinology fellowship at San Antonio Uniformed Services Health Education Consortium in San Antonio, TX. He served in the United States Air Force as an active duty endocrinologist until 2022, while also serving as the chief of medicine for Keesler Medical Center, associate program director for the Internal Medicine residency program, and flight commander for the medical specialties division.

PERSONAL MEDICAL HISTORY

Note: This is a confidential report of your medical history. Information contained here will be released only if you have authorized us to do so.

Endocrinology & Diabetes Clinic

Last Name:	First Name:	Middle Initial:
Date of Birth: / /	Gender: ○ Male ○ Female	Marital Status:
Preferred Pharmacy:	Pharmacy Phone Number:	
Pharmacy Address:		
Primary Care Provider:	Phone:	Referring Doctor:
Being seen today for:		

Past Medical History: *List any conditions you have had.*

Condition	Date

Family History:

parents, grandparents, brothers, sisters, children, aunts, uncles

Yes	No	Disease	Relative(s)
○	○	Asthma	
○	○	Cancer	
○	○	Diabetes	
○	○	Heart Disease	
○	○	High Blood Pressure	
○	○	Kidney Disease	
○	○	Mental Illness	
○	○	Other Glandular Disease	
○	○	Stomach Ulcers	
○	○	Stroke	
○	○	Thyroid Disease/Goiter	
○	○	Tuberculosis	

Health Maintenance: *Fill in all that apply.*

Date of last eye exam:
Date of last prostate exam:
Date of last mammogram:

Past Surgical History:

Type	Year
Recent Hospitalizations:	

Social History:

Do you use alcohol? ○ Never ○Formerly ○ Some Days ○ Every Day
Do you drink caffeinated beverages? ○ Yes ○ No
Have you ever smoked? ○ Never ○ Formerly ○Some Days ○ Every Day If yes, how many years have you smoked? Packs per day?
How often do you exercise? ○ Never ○ 1x per wk ○ 2-3x per wk ○ 4+x per wk
How many children do you have?
Highest level of education?
Occupation:

Symptoms: *Check all appropriate boxes indicating the symptoms you have had within the last year.*

Constitutional
- ○ Change in weight of more than 10 lbs
- ○ Night Sweats
- ○ Fatigue

Eyes
- ○ Trouble with Vision
- ○ Changes in Vision
- ○ Double Vision
- ○ Blurred Vision

Head ENT
- ○ Changes in Hearing
- ○ Hoarseness
- ○ Headaches

Cardiovascular
- ○ Palpitations
- ○ Chest Pain
- ○ Difficulty Breathing on Exertion
- ○ Lower Extremity Swelling
- ○ Loss of Consciousness

Respiratory
- ○ Chronic Cough
- ○ Coughing Blood
- ○ Shortness of Breath
- ○ Wheezing
- ○ Difficulty Breathing

Gastrointestinal
- ○ Difficulty Swallowing
- ○ Reflux
- ○ Nausea
- ○ Vomiting
- ○ Vomiting Blood
- ○ Diarrhea
- ○ Constipation
- ○ Blood in Stools
- ○ Changes in Bowel Habits

Genitourinary
- ○ Painful or Difficult Urination
- ○ Frequency
- ○ Excessive Urination at Night
- ○ Post Void Dribbling
- ○ Blood in Urine
- ○ Urgency

Musculoskeletal
- ○ Muscle Cramps
- ○ Nocturnal Leg Cramps
- ○ Joint Pain
- ○ Joint Swelling

Integument/Skin
- ○ Pigmentation Changes
- ○ Skin Dryness
- ○ Rash
- ○ New Skin Lesions
- ○ Changes to Existing Skin Lesions/Moles
- ○ Hair Growth Changes

Neurologic
- ○ Tremors
- ○ Speech Difficulties
- ○ Paralysis
- ○ Tingling or Numbness
- ○ Seizures
- ○ Muscular Weakness

Psychiatric
- ○ Anxiety
- ○ Depression
- ○ Difficulty Breathing

Endocrine
- ○ Cold Intolerance
- ○ Heat Intolerance
- ○ Drinking More Fluids
- ○ Excessive Urination
- ○ Excessive or Abnormal Thirst
- ○ Excessive Hair Growth
- ○ Hot Flashes

Hema-Lymph
- ○ Lymph Node Enlargement
- ○ Easy Bleeding
- ○ Easy Bruising

Allergic-Immuno
- ○ Sinus Allergy
- ○ Hay Fever
- ○ Allergic Dermatitis

Breasts
- ○ Changes in Skin
- ○ Masses
- ○ Nipple Discharge

Medications: *List all medicines and supplements you take.*

Medicine or Supplement	How much?	How often?

Allergies:

Are you allergic to any medications? ○ Yes ○ No

Please list:

Are you allergic to latex? ○ Yes ○ No

Are you allergic to any foods? ○ Yes ○ No

Please list:

I certify these two pages to be accurate and current to the best of my knowledge. *(Please sign & date below.)*

Patient Signature: _____ **Date:** _____

Endocrinology & Diabetes Clinic

201 Sivley Road Suite 440
Huntsville, Alabama 35801
Phone: (256) 265-0780 Fax: (256) 265-0781

PATIENT INFORMATION

PLEASE PRINT DATE_____

Patient's Name _____ Referred By _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone_____ Cell Phone_____

SS# _____-_____-_____ Sex M F D.O.B._____/_____/_____

Email Address _____

Patient's Occupation _____ Employer:_____ _____

Employer's Address _____Employer's Phone ( )_____ _____

Spouse's Name _____Spouse's D.O.B. _____/_____/_____ Spouse's SS # _____-_____-_____

Spouse's Occupation _____Spouse's Employer_____ _____

Employer's Address _____ Employer's Phone ( ) _____

Notify in case of emergency _____Relationship _____

City _____ State _____ Phone ( ) _____

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE ( )_____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature _____ Date _____Time_____

Name:_____ Date of Birth:_____

Diabetes Questionnaire

****Please note it is important that you bring your glucometer & blood glucose log to each appointment with Dr. Jindal****

1. At what age were you diagnosed with diabetes? _____
2. Do you have a diabetes-related complication: (please circle one)

   Retinopathy Kidney Disease Heart Disease Nerve Damage

3. What medications have you tried for diabetes in the past? (If additional space is needed, please write on the back of this page)

Medications	How Much / How Often	Why was it stopped?

4. How many meals do you eat in a day? _____Which meal is your largest?_____
5. How often do you snack?_____
6. What do you usually eat for snacking? _____
7. How many sugar-sweetened drinks or sodas do you drink daily?_____
8. What was your last A1c and when was it done?_____
9. How often do you check your blood sugar?_____
10. What are your blood glucose readings? Please provide a 50 point average range for each of the options below. (Example 100's-150's)

Before Breakfast Range	Before Lunch Range	Before Supper Range	At Bedtime Range

11. In the last two weeks have you had a blood sugar reading less than 70?_____
12. What time of the day do you usually have a reading less than 70?_____
13. At what blood glucose number do you feel the symptoms of low blood glucose? _____
14. Have you ever had pancreatitis or thyroid cancer? If so, which one?_____
15. Who is your eye doctor and when was your last exam?_____
16. Any weight gain or loss in the past six months? _____ How much? _____
17. Do you stay thirsty? _____
18. Do you have to get up at night to urinate? If so, how often? _____

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Name: _____ Date of Birth: _____

Thyroid Questionnaire

1. Have you been diagnosed with thyroid disease? If yes, please circle the diagnosis:

Hypothyroidism Hashimoto's Thyroiditis Graves Disease

Hyperthyroidism Thyroid nodule Goiter Thyroid cancer

2. Have you taken any treatment for thyroid disease? If yes, please indicate treatment type. _____

_____

3. What medications have you tried for Thyroid Disease in the past? (If additional space is needed, please write on the back of this page)

Medications	How Much / How Often	Why was it stopped?

4. Have you received contrast for a CT scan in the last 6 months? If yes, when? _____

5. Do you take, or have you ever taken, Amiodarone, lithium, or thyroid supplements? If yes, please indicate which one._____

6. Has your weight changed in last 6 months? If yes, how much did you lose or gain? _____

7. Do you have (please circle if it applies): difficulty breathing difficulty swallowing changes in voice

8. Does anyone in your family have thyroid cancer? If yes, please indicate who it is and the type of thyroid cancer. _____

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Name: _____ Date of Birth: _____

9. Have you received radiation to the head and neck before age 20?_____

10. Have you been diagnosed with cancer? If yes, what type of cancer?_____

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Name:_____ Date of Birth:_____

Bone/Parathyroid Disease Questionnaire

1. Have you ever had kidney stones? No Yes
2. Were you ever diagnosed with any cancer? No Yes, what kind? _____

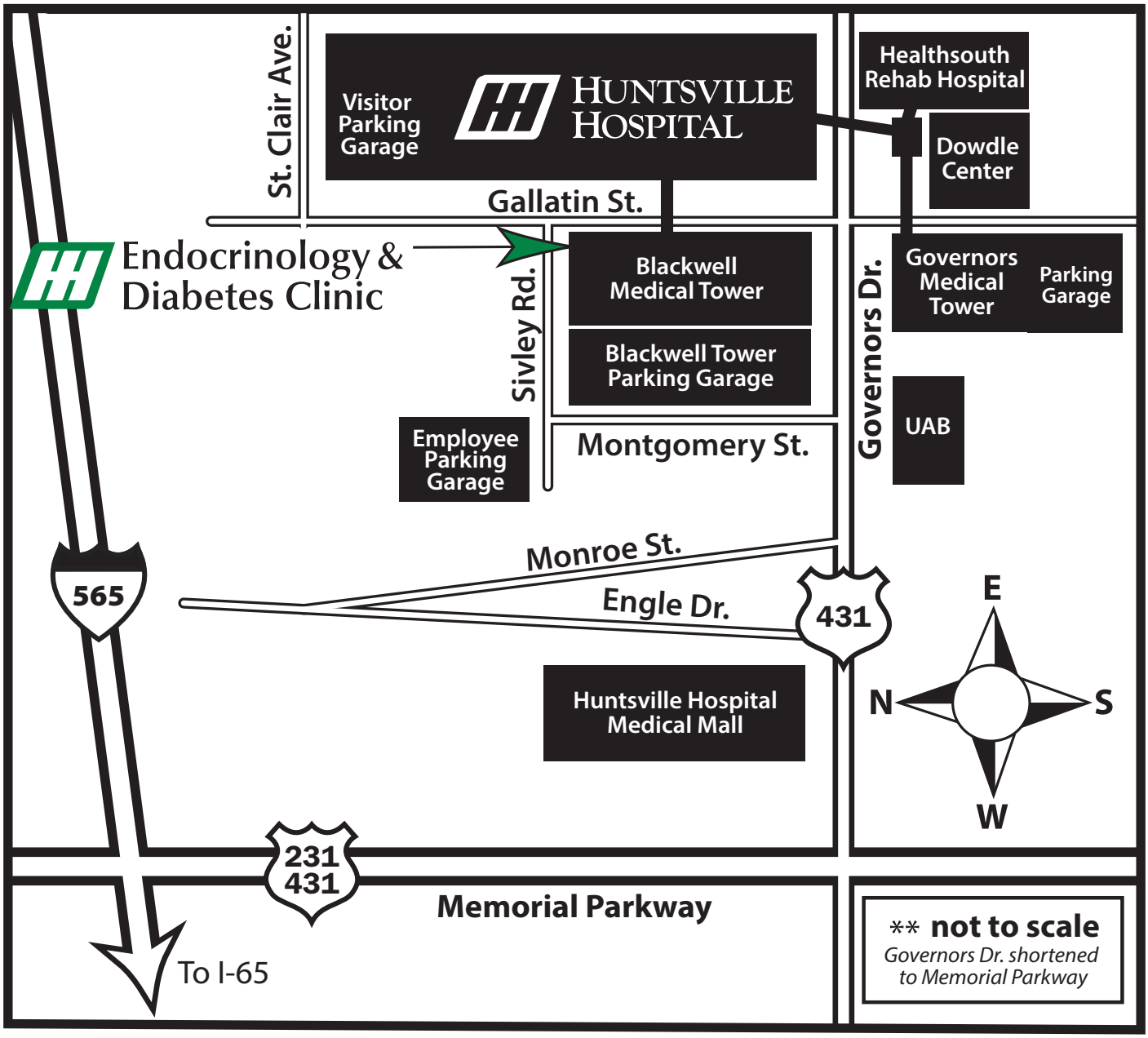
   _____
3. Please list the calcium supplements/Tums you take and the dosage_____

   _____
4. Please list the Vitamin D supplements and the dosage_____

   _____
5. Do you take calcitriol? No Yes, how much? _____
6. How many servings of dairy/milk products do you consume in a day? _____
7. Please list all bone fractures that you have sustained _____

   _____
8. When was your last bone scan/DEXA scan? _____
9. Have you ever taken any treatment for osteoporosis? No Yes, please list the medications along with the start/stop dates _____

   _____
10. Did you have any side effects with any medications for osteoporosis/weak bones? No Yes
11. Family history of high calcium? No Yes
12. Family history of parathyroid disease? No Yes
13. Have you ever had parathyroid surgery? No Yes
14. Have you ever been diagnosed with sarcoidosis? No Yes
15. Have you ever been diagnosed with lymphoma? No Yes
16. Have you ever been diagnosed with tuberculosis? No Yes
17. Do you take lithium? No Yes
18. Do you take hydrochlorothiazide (HCTZ) or chlorthalidone? No Yes



Going South on Memorial Parkway
Exit right onto Governors Drive
Left at the Governors Drive light
Left onto Gallatin Street (traffic light)
Left onto Sivley Road (traffic light)
Left into Blackwell Medical Tower Parking Garage
Please take elevators in the garage to the lobby level

Going North on Memorial Parkway
Exit right onto Governors Drive
Right onto Governors Drive
Left onto Gallatin Street (traffic light)
Left onto Sivley Road (traffic light)
Left into Blackwell Medical Tower Parking Garage
Please take elevators in the garage to the lobby level

Once you are inside the building
Select “4” on elevator
Take a left onto the hallway
Suite 440 will be the last office on your left - Endocrinology & Diabetes Clinic