Physicians' Building Group – Diabetes & Endocrinology

MEDICAL HISTORY

Patient Name: _____Date: _____

Reason for today's visit: _____

Have you ever had any of the following? (Please circle)

	NO	YES	If yes describe and list dates
1. Diabetes	N	Y	_____
2. High Blood Pressure	N	Y	_____
3. Stroke	N	Y	_____
4. Heart Attack/Angina	N	Y	_____
5. Heart Failure	N	Y	_____
6. Abnormal Heart Rhythm	N	Y	_____
7. Heart Murmur	N	Y	_____
8. Peripheral Vascular Disease	N	Y	_____
9. Carotid Artery Disease	N	Y	_____
10. Aortic Aneurysm	N	Y	_____
11. Heart Stents/Bypass/Pacemaker	N	Y	_____
12. High Cholesterol	N	Y	_____
13. High Calcium	N	Y	_____
14. Kidney Stones	N	Y	_____
15. Kidney Failure	N	Y	_____
16. Cancer	N	Y	_____
17. Liver Disease	N	Y	_____
18. Reflux Disease	N	Y	_____
19. Peptic Ulcer	N	Y	_____
20. Colon Polyps	N	Y	_____
21. Colon Cancer	N	Y	_____
22. Adrenal Tumors	N	Y	_____
23. Pituitary Tumors	N	Y	_____
24. History of Fractures	N	Y	_____
25. Osteoporosis	N	Y	_____
26. Sleep Apnea	N	Y	_____
27. Skin Moles/Freckles	N	Y	_____
28. Anxiety/Depression	N	Y	_____

If you have thyroid disease, please fill out the following information:

1. History of under active thyroid _____
2. History of overactive thyroid _____
3. History of radiation exposure as a child _____
4. Radioactive iodine treatment for grave's disease _____
5. History of thyroid nodule _____

Have you had thyroid biopsies? _____

6. History of thyroid cancer _____
7. Do you take thyroid hormones? _____

If you have diabetes, please fill out the following:

1. History of Type I _____ Type II _____ Gestational Diabetes _____
2. Age of diagnosis _____ Year of Diagnosis _____
3. Last A1C level _____ Date _____ Glucometer Used? _____
4. Are you on insulin? _____ what is your insulin regimen? _____

_____

5. How often do you check your blood glucose? Twice daily _____ Thrice daily _____
6. Were you ever admitted with very high blood glucose results? _____
   If so, when? _____
7. Do you have low blood sugars (below 70) _____ How often? _____
8. Has your weight changed in the last month(s)? _____ by how much? _____
9. Do you follow a diet plan? _____
10. Do you exercise? _____ How often? _____ For how long? _____

What type of exercise do you do? _____

11. Last eye exam date _____ Has diabetes affected your eyes? _____
12. Last dental exam date _____ Last foot exam date _____
13. Do you have foot ulcers? _____ Amputation of toes? _____
14. Do you suffer from pain, numbness and tingling in your feet or hands? _____
15. Do you have problems with constipation? _____ Frequent bowel movements? _____
16. Does food "stay in your belly for a long time" after you eat? _____
17. Do you suffer from dizziness when you stand up suddenly? _____
18. Have you ever had a stress test for your heart? _____ If so, when? _____

Immunizations/Screening Pneumovax _____ Flu Vaccine _____
Colonoscopy _____ Mammography _____

Current Medications (include over the counter and herbal supplements)

Name	Dose	Frequency

Social History

Smoking_____ Packs per Day _____ No of year's _____

Age at which started smoking _____ Age at which smoking stopped _____

Alcohol _____ Drinks per day _____ Drinks per week _____

Street drugs _____ Marijuana _____ Cups of coffee daily _____ Tea _____

Marital Status _____

Family History

	Age if living	Age at death	Current medical problems Or cause of death	Check if any blood relatives had:
Father				Diabetes……□
Mother				High BP……□
Sisters				Heart Attack……□
				Stroke..……□
				High Cholesterol..……□
Brothers				Thyroid Disease..……□
				Thyroid cancer…..……□
				High Calcium...……□
Children				Kidney Stones……□
				Peptic ulcer/GERD……...…□
				Osteoporosis…….……□
				Breast Cancer…...……□
Allergies				Pituitary tumor..……□
				PCOS……□
				Early menopause..……□
				Adrenal Tumor…..……□

Review of Systems (check the box if you have had any of the following to a significant degree)

Constitutional: ☐ weight changes ☐ fevers/chills ☐ night sweats ☐ fatigue ☐ change in appetite ☐ excessive thirst ☐ feeling excessively hot ☐ feeling excessively cold

Eyes: ☐ loss of vision ☐ blurry vision ☐ peripheral vision ☐ bulging eyes ☐ tearing or redness ☐ laser treatments ☐ bleeding within the eye ☐ retinal detachment

Heart: ☐ chest pain/tightness ☐ difficulty breathing with exertion ☐ difficulty breathing at rest ☐ palpitations ☐ swelling of feet ☐ unable to lie flat

GI: ☐ reflux symptoms ☐ abdominal pain ☐ nausea/vomiting ☐ diarrhea ☐ constipation

GU: ☐ straining while passing urine ☐ frequent urination ☐ waking u a t night to urinate several times ☐ blood in the urine ☐ urgency to pass urine

MS: ☐ falls ☐ fractures ☐ decrease in height ☐ bone pains ☐ muscle pain ☐ jaw pain/ulceration

☐ dental enamel problems ☐ change in glove or shoe size

Neurological: ☐ numbness/tingling in hands and feet ☐ headache ☐ tremors ☐ vertigo ☐ dizziness
☐ fainting spells ☐ seizures ☐ disrupted sleep ☐ snoring ☐ daytime sleepiness
☐ apnea spells (stopping breathing) ☐ weakness in arm or leg ☐ memory problems
☐ difficulty with concentration

Skin: ☐ excessive skin dryness ☐ acne ☐ excessive facial hair ☐ scalp hair loss ☐ loss of skin pigment
☐ skin tumors on face/chest/body ☐ excessive freckles/moles ☐ flushing ☐ excessive sweating
☐ wide purplish abdominal stretch marks ☐ brittle nails ☐ easy bruising

Psychiatric: ☐ anxiety ☐ depression ☐ mood swings/easy irritability

GYN: (women only)
Do you have regular periods? _____ How often? _____
Do you have irregular periods? _____Heaviness? _____
History of breast cancer? _____ Uterine cancer? _____
Fertility problems? _____ Any use of invitro techniques? _____
# of pregnancies? _____Miscarriages/abortions? _____
If menopausal, what age started? _____Low libido? _____
Do you use oral contraceptives? _____ Name of OC _____
Are you on hormone replacements? _____
History of PCOS _____ Excessive hair on face/body _____
Breast discharge/milk production _____

Male GU:
Low sex drive_____ Problems with erections _____ Use of testosterone _____
History of prostate enlargement _____Prostate Cancer _____
Loss of muscle mass _____ Loss of facial hair _____