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ADULT PATIENT HEALTH HISTORY

I. General Information:

Name:_____***Date of Birth:***_____
Street Address:_____Apt.#_____
City:_____State:_____ZIPCODE: _____
Home Phone:_____Work Phone:_____Cell Phone:_____
Pharmacy name & address:_____Phone#:_____

Emergency contact person:_____Relationship:_____
Address (if different from patient):_____
City:_____State:_____ZIPCODE:_____
Phone#:_____ Alternate Phone#:_____

Patient's Reason for Office Visit:_____
_____
_____

II. Medications:

Please list any known drug allergies or other negative reactions to medications:_____
_____
_____

Please list all diabetes medications separately on Page 5, Part VI "for patients with diabetes."

Below please list all other currently used medications including inhalers, vitamins and supplements.

Medication Name	Dose (mg, ml, sprays, etc.)	Frequency (per day, per week, etc.)	Age Started (or give date)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

III. General History:

Marital Status (check one): ___Single ___Married ___ Divorced ___ Separated ___ Widowed

Occupation:_____

Number of Children:_____Year of Birth for each_____

Smoking History (check one and fill in the blanks if indicated):

____ Never smoked.
____ Currently smoking. Age started:____How many cigarettes per day?_____
____ Quit smoking: Age started:_____ Age stopped:_____

Alcohol Intake (please check one): ____No ____Yes ____Occasionally
Number of drinks per day:____ **OR** Number of drinks per week:____

Exercise: Type:_____ Times per week:_____

Dietary Routine(check one): ____Balanced (all nutrition groups) ____ Diabetic ____Vegetarian
____Gluten Free ____Low Fat ____Low Sodium
____Lactose Intolerant ____Vegan
____Other: Please explain_____

IV. Family History: ____Check if adopted or no family history is known and proceed to next page.

Please check all that apply	Father	Mother	Grandfather		Grandmother		Brother	Sister
			Maternal	Paternal	Maternal	Paternal		
Diabetes								
Heart Disease								
Heart Attack								
Congestive Heart Failure								
High Blood Pressure								
Thyroid Problems								
Osteoporosis								
Kidney Disease								
Cancer If yes , type of Cancer:								

V. Patient Disease History:

Please list any serious or chronic illnesses. ____*Check if no history of such conditions.*

1._____Date or age:_____
2._____Date or age:_____
3._____Date or age:_____
4._____Date or age:_____
5._____Date or age:_____
6._____Date or age:_____
Use this area if additional space is needed:

VI. Major Surgeries: ***Please list below.*** ____*Check if no history of major surgery.*

1._____ Date or age:_____
2._____ Date or age:_____
3._____ Date or age:_____
4._____ Date or age:_____
5._____ Date or age:_____
6._____ Date or age:_____
Use this area if additional space is needed:

VII. Overall Health Review: ***Please check all conditions that apply.***

GENERAL		EARS/NOSE/THROAT		EYES	
Fever		Hearing impairment		Vision changes	
Chills		Hearing aid use		Vision loss	
Fatigue		Ringing in ears		Glaucoma	
Weakness		Neck pain		Cataracts	
Dizziness		Difficulty swallowing		Eye injuries	
Fainting		Hoarseness			
Headaches		Voice changes			
Stroke		Nosebleeds			
Pain					
Sleep Problems					

(continued on next page…)

Overall Health Review, continued from page 3 –

SKIN		PSYCHIATRIC SYMPTOMS	
Easy bruising	___	Depression	___
Dry skin	___	Anxiety	___
Rash	___	Memory Loss	___

URINARY SYSTEM		CARDIOVASCULAR SYSTEM	
Frequent urination	___	Heart palpitations ("pounding")	___
Difficulty urinating	___	Chest pains	___
Pain when voiding	___	Hypertension	___
Blood in urine	___		
Kidney stones	___		

ENDOCRINE and METABOLIC SYSTEMS REVIEW

I. General review -- Please check all conditions that apply:

For Men and Women:		For Women Only:	
Rapid weight change	___	Irregular menstrual periods	___
Heat intolerance	___	Excessive facial or body hair	___
Cold intolerance	___		

II. Women with excessive facial or body hair -- please provide the following information:

Where is the hair located?_____
When did it appear?_____
Are menstrual periods regular?_____
Has there been rapid weight change?_____

III. Patients with kidney stones -- please provide the following information:

How many times have you had kidney stones:_____At what age(s)?__ _____
Were stones passed without hospitalization? (check one) Yes___ No___ If no, what procedure was used to remove stones? _____ _____ _____
Do you now have kidney stones? (check one) Yes___ No__
Have previous stones been analyzed? (check one) Yes___ No___ If yes, what were the results of analysis?_____ ____ _____
Have you been evaluated for cause of stone formation? (check one) Yes___ No___ If yes, what were the results of evaluation?_____

IV. <u>Patients with thyroid problems</u> -- please indicate (check) if you have the following:

Enlarged thyroid	Yes	No
Thyroid nodule(s)	Yes	No
Underactive thyroid	Yes	No
Overactive thyroid	Yes	No
Thyroid cancer	Yes	No

V. <u>Patients with bone loss</u> (osteoporosis or osteopenia) – please provide the following information:

Date of last bone density exam:_____
Have you had bone fractures? (check one) Yes No If yes, indicate which bones and date of fracture for each _____
_____
Have you had any loss of height? (check one) Yes No If yes, how many inches? _____
What has been your tallest height measurement?_____feet _____inches

VI. <u>Patients with diabetes</u> -- please complete the following section:

1. General information:

Age of Diagnosis _____ Date of last eye exam:_____
Date of last microalbumin_____ Results (check one): Normal_____Abnormal_____
Date of last Hgb A1C _____ Value:_____%
Do you use a glucose meter? (check one) Yes____ Brand name:_____ No____
Frequency of blood sugar testing_____times per day.
Blood sugar range_____ _____
Do you use a CONTINUOUS GLUCOSE MONITOR (CGM)? Yes____ No____

2. Patients using oral medication only OR using oral medication plus insulin:

List oral medications: 1._____Dose_____
2._____Dose_____
3._____Dose_____
4._____Dose_____

Do you use oral medication plus insulin? Yes____ No____
If yes, please provide the following information:
Long acting insulin -- Brand:_____
Time of day and amount for each:_____
Short acting Insulin -- Brand:_____
Time of day and amount for each:_____
Pre-mixed Insulin -- Brand:_____
Time of day and amount for each:_____

(SECTION 2 CONTINUED ON NEXT PAGE)

ENDOCRINE and METABOLIC SYSTEMS REVIEW, part VI, for patients with diabetes, section 2,
Continued from page 5 –

For patients using oral medication plus insulin:
Do you adjust your insulin?_____If so, by what method? _____
_____

3. Patients injecting insulin only -- please provide the following information:

Long acting insulin -- Brand:_____
Time of day and amount for each:_____
Short acting Insulin -- Brand:_____
Time of day and amount for each:_____
Pre-mixed Insulin -- Brand:_____
Time of day and amount for each: _____

Do you adjust your insulin?_____If so, by what method?_____
_____

4. Patients using an insulin pump -- please provide the following information:

Brand of pump:_____Date started:_____
Basal Insulin Rates:_____
Insulin/Carb Ratio: _____
Insulin Correction Factor:_____

I AFFIRM THAT THE INFORMATION REGARDING MY HEALTH PROVIDED ON THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature of Patient:_____Date:_____
OR:
Signature of Authorized Representative_____Date:_____
Please print representative's name:_____
Relationship to patient:_____

Thank you for completing this health history form. This important information will help us to better serve your health care needs.