



Patient's Name: _____

Age: _____

Account No. _____

DOB: _____

Health History

PLEASE PRINT

Past Medical History

Please list all medical problems and approximate dates of onset: (Example: Diabetes, Hypertension, Heart Disease, Thyroid Cancer, etc.)

Hospitalizations

Please list all hospitalizations, include dates and reasons, including surgeries:

Bone fractures and injuries

Please list all injuries such as bone fractures, etc:

Birthing and Menstrual History

Number of pregnancies: _____

Number of live births: _____

Age of each pregnancy: _____

Weight of babies: _____

Complications: _____

Age when period started: _____

Date of last period: _____

Frequency/ length of periods: _____

Pain with periods: _____

Hot flashes or sweats: _____

Psychiatric

Please list any history of depression, hospitalization for mental illness, suicidal thoughts?

Patient's Name: _____

Review of Body Systems

(Please Print)

Weight- Have you gained or lost weight? _____

Height- Have you lost height? _____

General- Fatigue, fever, chills, tolerance of heat and cold? _____

Head- Headaches, loss of consciousness, dizziness? _____

Eyes- Vision change, eye pain or dry feelings, double vision, eye bulging? _____

Mouth- Hoarseness, dental problems, bleeding after brushing? _____

Nose- Bleeding, frequent sinus infectious? _____

Neck- Stiffness, pain, swelling, goiter? _____

Breast- Masses, tenderness, nipple discharge? _____

Last mammogram? _____ **Where?** _____

Chest- Pain, cough, bringing up blood, night sweats? _____

Cardiac- How far can you walk? _____

Any chest pain or tightness? _____

Irregular heart beat? _____

How many pillows do you sleep on? _____

History of heart murmur or rheumatic fever? _____

Muscle/ Bone- Arthritis, joint pain or swelling, leg edema? _____

Nerves- Problems with strength, balance, numbness, pain or needles and pins feelings in the extremities, tremor, falls, blackouts? _____

Skin- Rash, itching, jaundice, increased hair of body? _____

Urinary- Problems with stopping or starting urine stream, pain with urination, history of urinary infections, prostate problems, blood in urine, loss of control of urination? _____

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3/30/2009

Diabetes & Glandular Disease Clinic, P.A

Patient's Name: _____

Review of Body Systems (cont)

(PLEASE PRINT)

Sexual- Male- Problems with potency or ejaculation? _____

Female- Painful intercourse, problems with lubrication, vaginal discharge?

Medications- Include over the counter medications:

<u>Name</u>	<u>Dosage</u>	<u>Date Started</u>	<u>For what condition</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies- Medicine _____

Food _____

Social History

Smoke _____ **Packs/ Days For how long?** _____ **When did you quit?** _____

Alcohol (indicate amount of intake per week): _____

Exercise: Type of exercise: _____

Times per week: _____

Sedentary _____ Low _____ Moderate _____ Intense _____
Sleep: Sleep all night? _____ Insomnia? _____
Typical Diet: Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Caffeine: Coffee _____ Tea _____ Sodas _____ Chocolate _____

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3/30/2009

Patient's Name: _____

Family History (Please state disease and if deceased, at what age)

Father: _____

Mother: _____

Brother: _____

Sister: _____

Other family: _____

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