Carolinas HealthCare System

Mecklenburg Medical Group
Department of Endocrinology
PERSONAL HEALTH HISTORY INFORMATION
All questions contained in this questionnaire are strictly confidential and will become part of your medical records

Name (First, MI, Last)	Date:	Date of Birth:

Reason for referral to our practice: _____

MEDICAL HISTORY

( ) High Blood pressure ( ) Heart attack ( ) Diabetes ( ) Asthma, Hay fever
( ) High Cholesterol ( ) Thyroid Disorder ( ) Pneumonia ( ) Stroke

Other past or current medical condition:

Surgeries:

Hospitalization /Major Injuries:

Significant health conditions of your family members (particularly endocrine conditions):

( ) Diabetes: Type 1 or Type 2	___ Parents	___ Siblings	___ Children	___ Other: _____
( ) Thyroid:				
Hypothyroid	___ Parents	___ Siblings	___ Children	___ Other: _____
Hyperthyroid	___ Parents	___ Siblings	___ Children	___ Other: _____
Thyroid nodule	___ Parents	___ Siblings	___ Children	___ Other: _____
Thyroid cancer	___ Parents	___ Siblings	___ Children	___ Other: _____
( ) Other:	___ Parents	___ Siblings	___ Children	___ Other: _____

MEDICATIONS

List your medications, including: prescribed drugs, birth control, pain medication, sleep aids, over-the-counter vitamins and supplements.

NAME	DOSE	FREQUENCY

ALLERGIES

List allergies or adverse reactions to medications or other substances below (Include drug name and allergic reaction)

SOCIAL HISTORY

( ) Married ( ) Single ( ) Divorced ( ) Widowed

Occupation: _____

Education: _____

What do you do for exercise?

What do you do for relaxation?

What methods do you use to control your weight?

Do you use: (Place an X in the circle next to those you use)

( ) Cigarettes	How much:	How often:
( ) Pipe	How much:	How often:
( ) Cigars	How much:	How often:
( ) Chewing tobacco	How much:	How often:
( ) Beer	How much:	How often:
( ) Wine	How much:	How often:
( ) Hard liquor	How much:	How often:
( ) Recreational drugs	How much:	How often:

If yes, please list what type: _____

SEXUAL/MENSTRUAL HISTORY

Are you sexually active?

Are you using birth control? Which type?

When was your last period?

Are you trying to become pregnant?

REVIEW OF SYSTEMS

Name (First, MI, Last)	Date:	Date of Birth:

PLACE AN X IN ANY CIRCLE TO A PROBLEM OR DISTURBANCE YOU HAVE HAD IN THE PAST YEAR

CONSTITUTION	( ) Recent weight changes	( ) Changes in appetite	( ) Persistent fever or chills
	( ) Night sweat or hot flashes	( ) Heat or cold Sensitivity	( ) Tire easily /Fatigue
	( ) Weakness or paralysis		
SKIN/HAIR/NAILS	( ) Skin rash	( ) Dry skin	( ) Change in hair or Nails
	( ) Excessive perspiration	( ) Skin itching	( ) Wounds
EYES	( ) Glasses or contacts	( ) Infected eyes	( ) Change in eye shape (Graves' disease)
	( ) Eye redness	( ) Blurred / double vision	
EARS	( ) Ringing in the ears	( ) Discharge from Ears	( ) Ear pain
	( ) Decrease in hearing		
NECK/THROAT	( ) Neck swelling	( ) Neck stiffness	( ) Sore throat
	( ) Persistent hoarseness	( ) Difficulty swallowing	( ) Swollen lymph glands
CHEST	( ) Frequent cough	( ) Wheezing	( ) Shortness of breath
	( ) Bloody sputum	( ) Painful breathing	( ) Chest pain discomfort
HEART	( ) Swelling of hands and feet	( ) Palpitations	( ) Leg cramp on walking
	( ) Enlarged veins		
STOMACH	( ) Abdominal cramping	( ) Nausea/vomiting	( ) Chronic diarrhea
	( ) Chronic constipation	( ) Rectal bleeding	( ) Black tarry stools
	( ) Heartburn		
URINARY TRACT	( ) Frequent urination	( ) Increase in thirst	( ) Painful urination
NEURO/PSYCH	( ) Numbness / tingling	( ) Tremor	( ) Headaches
	( ) Memory loss	( ) Sleep changes	( ) Depressed mood
	( ) Anxiety		
MUSCLES	( ) Backaches	( ) Joint pain/stiffness	( ) Swollen joints
MEN ONLY	( ) Difficulty with erection	( ) Testicle lump / pain	( ) Penis discharge
WOMEN ONLY	( ) Period absent	( ) Days between period	( ) Heavy flow
	( ) Menstrual pain / cramps	( ) Bloody discharge	( ) Other discharge
	( ) Breast lump / discharge	( ) Breast pain	Date of last mammogram:
	# Pregnancies _____	# Living births _____	_____

*Is there anything else you would like your doctor to know?

DIABETES HISTORY FORM

Please complete this page if you are a diabetic

Name (First, MI, Last)	Date:	Date of Birth:

What year were you diagnosed with diabetes? How old were you?

Have you ever had any diabetes related complications?

( ) High blood pressure?

( ) High cholesterol?

( ) Heart attack?

( ) Stroke or TIA?

( ) Pain /cramps in lower legs with walking?

( ) Erectile dysfunction?

( ) Diabetic eye disease or previous laser treatment?

( ) Nerve problems (numbness/ tingling)?

( ) Kidney problems or protein in your urine?

( ) Foot ulcers or deformities?

( ) Dental problems or gum disease?

( ) Depression?

<u>Have you ever been hospitalized for uncontrolled blood sugar? When & where?</u>

If you take insulin, what year did you start?

Do you check your blood sugars at home?

During the past month, what have your sugars been?

*Fasting/ pre-breakfast sugars:	Highest:	Lowest:	Average:
*Pre-lunch sugars:	Highest:	Lowest:	Average:
*Pre-dinner sugars:	Highest:	Lowest:	Average:
*Bedtime sugars:	Highest:	Lowest:	Average:

Have you had a flu shot during this flu season (between October and February)?
**if you have not had a flu shot: A yearly flu shot is recommended to people with diabetes.

When was your last eye exam?
**It is recommended that all people with diabetes have a yearly eye exam.

Do you see a podiatrist? If so, when was your last exam?

Please remember to bring your blood sugar meter and blood sugar record to your appointment.