

HEALTH HISTORY

Iowa Diabetes and Endocrinology Center

Name (Print) _____ Date of Birth _____

I certify that the following information is accurate. I will not hold my physician or any members of his/her staff responsible for any errors or omissions made when completing this form.

Signature _____ Today's Date _____

Who is your appointment with today? _____

What is your reason for visit? _____

MEDICATIONS List current prescription medication amount and time taken. <i>(or provide list if you have one)</i>		
Name of Medication	Dosage Amount	Time Taken

ALLERGIES List any allergies to medications.

PHARMACY NAME/ADDRESS:
PHARMACY PHONE: ()

May we fax prescriptions to your pharmacy? (Mark (x) box if ok)

PAST MEDICAL HISTORY Mark (x) all that apply.			
<input type="checkbox"/> Acid Reflux Disease	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Chol./High Triglycerides	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV Disease	<input type="checkbox"/> Polio
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irregular Menstrual Periods	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma/Lung Problem	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis/Osteopenia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker	

SURGICAL HISTORY List past surgeries and year.	PAST HOSPITALIZATIONS List reason and year.

FAMILY HISTORY Complete health information about your family.

RELATION	AGE	STATE of HEALTH	AGE at DEATH	Cause of Death	Mark (×) if applies to blood relative.	Relationship to you
Father					Diabetes	
Mother					Thyroid Disease	
Brothers					High Blood Pressure	
					Heart Disease	
					Stroke	
					Breast Cancer	
Sisters					Ovarian Cancer	
					Prostate Cancer	
					Colon Cancer	
					Osteoporosis	
					High Chol/High Trig	

SOCIAL HISTORY Mark (×) all that apply.

Marital Status: Single Married Separated Divorced Widowed
Living Situation: Alone Partner Parents Children (# of children ____) Nursing Facility
Occupation: Job Title _____ Retired Unemployed Student

HEALTH HABITS Mark (×) what substances you use and describe how much you use.

Caffeine	
Tobacco	
Alcohol	
Drugs	

SYMPTOMS Mark (×) symptoms that pertain to you.

<p>GENERAL</p> <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Excessively tired <input type="checkbox"/> Discomfort <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <p>RESPIRATORY</p> <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Coughing up sputum <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Wheezing <input type="checkbox"/> Snoring <p>MUSCULOSKELETAL</p> <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Stiffness <input type="checkbox"/> Arthritis <p>HEME/LYMPHATIC</p> <input type="checkbox"/> Abnormal bruising <input type="checkbox"/> Bleeding <input type="checkbox"/> Enlarged lymph nodes	<p>EYES</p> <input type="checkbox"/> Blurring <input type="checkbox"/> Double vision <input type="checkbox"/> Irritation <input type="checkbox"/> Discharge <input type="checkbox"/> Vision loss <input type="checkbox"/> Eye pain <input type="checkbox"/> Intolerance of light <input type="checkbox"/> Swelling <p>GASTROINTESTINAL</p> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Stomach pain <input type="checkbox"/> Rectal bleeding/bloody stools <input type="checkbox"/> Indigestion/Heart Burn <input type="checkbox"/> Excessive gas <p>SKIN</p> <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Suspicious wounds <p>NEUROLOGIC</p> <input type="checkbox"/> Temporary paralysis <input type="checkbox"/> Weakness <input type="checkbox"/> Tremors <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Headache <p>ALLERGIC/IMMUNOLOGIC</p> <input type="checkbox"/> Skin conditions <input type="checkbox"/> Hay fever <input type="checkbox"/> Persistent infections <input type="checkbox"/> HIV exposure	<p>EARS/NOSE/THROAT</p> <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Ringing/Buzzing in ears <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Sore Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Difficulty swallowing <p>WOMEN ONLY</p> <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Poor bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Absent menstrual period <input type="checkbox"/> Irregular menstrual period <input type="checkbox"/> Decreased sex drive <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Breast lump <p>PSYCHIATRIC</p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Paranoia <input type="checkbox"/> Memory loss <input type="checkbox"/> Mental disturbance <input type="checkbox"/> Suicide thoughts <input type="checkbox"/> Hallucinations	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain/pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <p>GENITO-URINARY</p> <p><i>MEN ONLY</i></p> <input type="checkbox"/> Painful urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Poor bladder control <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Decreased sex drive <input type="checkbox"/> Breast lump <p>ENDOCRINE</p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Frequent thirst <input type="checkbox"/> Increased hunger <input type="checkbox"/> Increased urination <input type="checkbox"/> Weight loss or gain
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