

## *Southwest Diabetes & Endocrinology*

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Primary care physician (PCP): \_\_\_\_\_

Referring physician (if different than your PCP) \_\_\_\_\_

Your preferred pharmacy/address/Phone number: \_\_\_\_\_

Mail order pharmacy: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Allergies (Drugs, food, environment, etc)	Reaction
1.	
2.	
3.	

Medications (include supplements, vitamins and herbs)-Dose and Frequency/Prescriber	Medications (include supplements, vitamins and herbs)-Dose and Frequency/Prescriber
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

### Health conditions or problems-check (✓) conditions you have or have had in the past

<input type="checkbox"/> Aids or HIV <input type="checkbox"/> AFIB <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Back Problems <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Blood Transfusions <input type="checkbox"/> Breast lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Celiac disease <input type="checkbox"/> COPD <input type="checkbox"/> Depression <input type="checkbox"/> Eczema <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes <input type="checkbox"/> Fractures <input type="checkbox"/> GERD <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart stents <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> High Blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Kidney stones <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Migraines <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mumps <input type="checkbox"/> Obesity <input type="checkbox"/> Osteopenia	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Peptic ulcer <input type="checkbox"/> Prostate problem <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Vaginal infections  <p style="text-align: center;"><b>List Dates</b></p> <input type="checkbox"/> Last Physical _____ <input type="checkbox"/> Last lab draw _____ <input type="checkbox"/> Sleep study if done/Date _____ <input type="checkbox"/> Bone Density (DXA) if done/Date _____	<p><b>If you are here for Diabetes visit</b></p> <input type="checkbox"/> Glucometer brand _____ <input type="checkbox"/> Diabetes education _____ <input type="checkbox"/> Last dilated eye exam _____ <input type="checkbox"/> Last foot exam _____ <input type="checkbox"/> Dental Exam _____ <input type="checkbox"/> Last Flu shot _____ <input type="checkbox"/> Last Pneumonia shot _____ <input type="checkbox"/> Any cardiac stress test _____ <input type="checkbox"/> Any Vascular studies _____ <input type="checkbox"/> Ophthalmologist _____ <input type="checkbox"/> Podiatrist _____
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To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

Signature of the patient/ personal representative \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

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Please list any other medical conditions not mentioned:		
1.	3.	5.
2.	4.	6.

### Check Operations performed / year performed:

<input type="checkbox"/> Angioplasty /	<input type="checkbox"/> Carotid artery surgery/	<input type="checkbox"/> Ear Surgery/	<input type="checkbox"/> Hysterectomy/	<input type="checkbox"/> Sinus/	<input type="checkbox"/> Thyroid /
<input type="checkbox"/> Appendectomy/	<input type="checkbox"/> Carpel tunnel surgery/	<input type="checkbox"/> Eye surgery/	<input type="checkbox"/> Knee surgery/	<input type="checkbox"/> Stomach/	<input type="checkbox"/> Trauma related/
<input type="checkbox"/> Bladder surgery/	<input type="checkbox"/> coronary bypass/	<input type="checkbox"/> Gall bladder surgery/	<input type="checkbox"/> Neurosurgery/	<input type="checkbox"/> Tonsillectomy/	<input type="checkbox"/> Other _____
<input type="checkbox"/> Breast surgery/	<input type="checkbox"/> Chest/Lung surgery/	<input type="checkbox"/> Hip surgery/	<input type="checkbox"/> Ovary removed/	<input type="checkbox"/> Tubal ligation/	<input type="checkbox"/>
<input type="checkbox"/> Back/Neck surgery/	<input type="checkbox"/> C-section/	<input type="checkbox"/> Hernia surgery/	<input type="checkbox"/> Prostate/	<input type="checkbox"/> Vascular surgery/	<input type="checkbox"/>

### Hospitalizations if any:

Year	Hospital	Reason for hospitalization/Outcome

### Social History:

Marital Status:  single  married  Divorced \_\_\_\_/\_\_\_\_/\_\_\_\_  Widowed \_\_\_\_/\_\_\_\_/\_\_\_\_

Number of children: \_\_\_\_\_ Highest level of education: \_\_\_\_\_

Occupation: \_\_\_\_\_  Retired \_\_\_\_\_  Active \_\_\_\_\_

Physical Activity/Exercise: \_\_\_\_\_ Frequency: \_\_\_\_\_

Smoking  No  Yes: type and amount \_\_\_\_\_ Number of Years \_\_\_\_\_

If former smoker, date quit: \_\_\_\_\_

Alcohol  No  Yes type and amount: \_\_\_\_\_ Number of years \_\_\_\_\_

When was your last drink \_\_\_\_\_ If quit- date \_\_\_\_\_

Caffeine  No  Yes Type \_\_\_\_\_ Street Drugs:  No  Yes Type \_\_\_\_\_ If Quit- date \_\_\_\_\_

### Family History- Please check (✓) if any family members have the conditions below

Relationship	cancer	Diabetes	Drugs/ Alcohol	Heart Disease	Kidney Disease	Obesity	stroke	Thyroid	High cholesterol	High Blood Pressure	Osteoporosis
Mother											
Father											
Sister											
Brother											
Daughter											
Son											
Mat. Aunt											
Mat. Uncle											
Pat. Aunt											
Pat. Uncle											
M.Grandmother											
M.Grandfather											
P.Grandmother											
P.Grandfather											

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**Review of Systems- Check (✓) symptoms you currently have: Please check only current symptoms**

<p><b>General</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Change in appetite</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Poor concentration</li> <li><input type="checkbox"/> Memory Loss</li> <li><input type="checkbox"/> Generalized Weakness/Tiredness</li> <li><input type="checkbox"/> Weight gain</li> <li><input type="checkbox"/> Weight loss</li> </ul>	<p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sores that don't heal</li> <li><input type="checkbox"/> Purple stretch marks</li> <li><input type="checkbox"/> Severe dry skin</li> <li><input type="checkbox"/> New facial hair</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Change in moles</li> </ul>	<p><b>Ears-Nose-Mouth-Throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding gums</li> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Ear ache /Discharge</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Neck masses</li> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Sore Throat</li> <li><input type="checkbox"/> Loss of Smell</li> </ul>
<p><b>Eyes /Head</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Peripheral vision loss</li> <li><input type="checkbox"/> Eye Pain</li> <li><input type="checkbox"/> Severe headaches</li> </ul>	<p><b>Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Excessive snoring</li> <li><input type="checkbox"/> Bloody sputum</li> </ul>	<p><b>Cardiovascular</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain or discomfort</li> <li><input type="checkbox"/> Irregular heart beat</li> <li><input type="checkbox"/> Rapid heart rate</li> <li><input type="checkbox"/> Poor circulation</li> <li><input type="checkbox"/> Swelling of ankles</li> <li><input type="checkbox"/> Varicose veins</li> </ul>
<p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Change in bowel habits</li> <li><input type="checkbox"/> Indigestion/Heart burn</li> <li><input type="checkbox"/> Nausea/Vomiting</li> <li><input type="checkbox"/> Abdominal pain</li> <li><input type="checkbox"/> Bloating/Gas</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Black stools</li> <li><input type="checkbox"/> Rectal bleeding</li> </ul>	<p><b>Endocrine</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Hair loss</li> <li><input type="checkbox"/> Sensitivity to heat</li> <li><input type="checkbox"/> Sensitivity to cold</li> </ul>	<p><b>Neurology</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Numbness/ tingling/ in hands or feet</li> <li><input type="checkbox"/> Tingling around lips of fingertips</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Insomnia</li> <li><input type="checkbox"/> Black outs</li> </ul>
<p><b>Musculoskeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Pain in the joints</li> <li><input type="checkbox"/> Frequent muscle spasms</li> <li><input type="checkbox"/> Stiffness</li> <li><input type="checkbox"/> Difficulty arising from a chair/climbing stairs</li> </ul>	<p><b>Men only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Erection difficulties</li> <li><input type="checkbox"/> Poor sex drive</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Sore on penis</li> <li><input type="checkbox"/> Lump in testicles</li> <li><input type="checkbox"/> Decrease force/flow/dribbling</li> <li><input type="checkbox"/> Difficulty initiating urine stream</li> </ul>	<p><b>Women Only</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Breast discharge</li> <li><input type="checkbox"/> Age periods began_____</li> <li><input type="checkbox"/> How many days in between_____</li> <li><input type="checkbox"/> Is flow heavy_____</li> <li><input type="checkbox"/> How many days do they last_____</li> <li><input type="checkbox"/> Extreme menstrual pain/Cramps</li> <li><input type="checkbox"/> Bleeding between periods</li> <li><input type="checkbox"/> Hot flashes</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Abnormal pap smear</li> <li><input type="checkbox"/> Date of last Menstrual period_____</li> <li><input type="checkbox"/> Date of last pap smear_____</li> <li><input type="checkbox"/> Date of last mammogram_____</li> <li><input type="checkbox"/> Birth Control If any/type_____</li> <li><input type="checkbox"/> Age of Menopause_____</li> </ul>
<p><b>Psychology</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anxious</li> <li><input type="checkbox"/> Depressed</li> </ul>	<p><b>Genito-Urinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Lack of bladder control</li> <li><input type="checkbox"/> Painful Urination</li> <li><input type="checkbox"/> Poor Sex Drive</li> </ul>	
<p><b>Hematology/Lymphatic</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Swollen glands</li> </ul>		

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