



SAINT MARY'S
HEALTH CARE

Diabetes & Endocrine Center

Medical History

Name _____ **Date of Birth** _____

Address _____

Phone _____

Past medical history - have you had any medical or surgical treatment for:

	Yes	No	When?
Anxiety, depression, or mental illness			
Substance abuse			
Diabetes			
Cancer			
High blood pressure or stroke			
Heart disease or heart attack			
Cholesterol or Triglycerides			
Eye problems (cataracts, glaucoma, retina)			
Nose, throat or hearing problems			
Thyroid or parathyroid glands			
Blood clots in the legs or lungs			
Lung problems (emphysema or asthma)			
Esophagus or stomach problems (ulcers, reflux)			
Intestinal or colon problems			
Liver, pancreas or gallbladder problems			
Kidney or bladder diseases			
Bone, joint or spinal surgery			
Breast surgery			
Men: prostate problems			
Women: breast, uterus or ovary problems			

Social history

How many yrs of school have you completed? _____ What is your occupation? _____

Are you employed now? _____ Retired? _____ Unemployed? _____ Homemaker? _____

Disabled? _____ What is your disability? _____

Are you currently married? Yes No Never married Divorced Widowed

Do you use:	now?	how much?	in the past?	when did you stop?
Caffeine				
Tobacco				
Alcohol				
Recreational drugs				

Do you exercise regularly? Yes No In what way? _____

Family history (answer questions only about blood relatives) Are you adopted? Yes No

	Alive (Age)	Deceased (age)	Health status	Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
	# Alive	Ages	# Deceased	Cause of death
Brother	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Sons	_____	_____	_____	_____
Daughters	_____	_____	_____	_____

Any blood relatives with thyroid disease or pituitary disease, high cholesterol, diabetes, high blood pressure or stroke, heart attack, adrenal disorders or cancer? (circle those that apply)

Current medications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug allergies or reactions

Medication

type of reaction

Review of Systems

Check any positive symptoms or problems you have experienced in recent months

	Yes	No
Fainting, loss of consciousness, seizures		
Dizziness or balance problems		
Loss of appetite or weight		
Fevers or chills		
Change in sleep		
Excessive thirst		
Skin rashes, bruising, stretch marks		
Change in pigment, abnormal hair growth		
Headaches, double vision, eyelid swelling		
Excessive tearing, light sensitivity		
Nose or sinus difficulty, voice change		
Dry mouth, difficulty swallowing, dentures		
Shortness of breath, cough, wheezing		
Chest pain or pressure, irregular heart beat		
Heartburn, ulcers, nausea, vomiting		
Diarrhea, constipation		
Kidney stones, frequent urination at night		
Pain in the joints or muscles, broken bones		
Numbness or pain in the feet or hands		

Women	
Age when you started menstrual cycles	
Age when you stopped	
Are you having regular cycles now?	
How many pregnancies?	
Could you be pregnant now?	
Any breast discharge not related to pregnancy or nursing?	

Men	
Any prostate or urinary problems?	

Loss of sexual desire or erectile dysfunction?	
--	--