Patient Medical History

Patient's Name: ______________________ **Date:** __________ **Chart#:** __________

Social History

Marital Status: Single___ Married___ Divorced___ Widowed___

Occupation: ______________________________

Exercise Habits: Sedentary___ Modestly Active___ Very Active___

Current Smoker: Yes___ No___ Previous Smoker: Yes___ No___
If yes: #of packs___ # of years___

Alcohol: Never___ Rare___ Weekly___ Daily___ Currently Using___
Illicit Drug Use: None___ Prior Problem___
How much (in time shown above) ______________

Constitutional	Y	N
Chills		
Fatigue		
Fever		
Night Sweats		
Weight Loss		
Eyes		
Difficulty seeing		
Double vision		
Eye pain		
Glasses/Contacts		
Ear/Nose/Throat		
Difficulty hearing		
Dizziness		
Frequent nose bleeds		
Frequent sore throat		
Hoarseness		
Nasal stuffiness		
Ringing in ears		
Sinus trouble		
Tooth or gum problems		
Cardiovascular		
Chest pain		
Difficulty lying flat		
Fainting spells		
Irregular heartbeat		
Leg pain while walking		
Murmur		
Palpitations		
Short of breath		
Swollen ankles		
Respiratory		
Cough		
Coughing blood		
Wheezing		

Gastrointestinal	Y	N
Abdominal pain		
Black/tarry stool		
Changes in appetite		
Changes in bowel habits		
Constipation		
Diarrhea		
Difficulty swallowing		
Heartburn		
Incontinence of stool		
Jaundice		
Persistant nausea/vomit		
Rectal bleeding		
Severe indigestion		
Genitourinary		
Abnormal urine discharge		
Blood in urine		
Burning urination		
Difficulty urinating		
Excessive urination night		
Frequent urination		
Frequent urine infections		
Pain on urination		
Sugar/protein in urine		
Urine incontinence		
Female Only		
Irregular periods	______	
Age onset periods	______	
Age menopause	______	
Last period ended	______	
Hematological/Lymphatic		
Enlarged lymph glands		
Prolonged bleeding		
Easy bruising		

Musculoskeletal	Y	N
Back pain		
Joint pain/swelling		
Muscle pain		
Stiffness		
Skin		
Change in hair or skin		
Itching or burning of skin		
Other skin lesions		
Rashes or sores		
Neurologic		
Difficulty speaking		
Memory loss		
Numbness		
Severe frequent headaches		
Tremors		
Severe weakness/paralysis		
Endocrine		
Changes in nails		
Decreased sex drive		
Excessive thirst		
Hay/cold intolerance		
Loss of hair		
Males Only		
Problem with erections		
Allergic/Immunologic		
Hay fever symptoms		
Hives		
Psychiatric		
Anxiety/depression		
Attempted suicide		
Hallucinations		
Insomnia		
Mood swings		
Other symptoms:		

Medication Allergies:

Reviewed by: ______________________ **Date:** ______________

diabetes and endocrine center of orlando

Initial Visit Medical History

Patient's Name: ______________________________ **Date**: _______________ **Chart #**: ___________________

Past Medical History: Please check each item in the area indicated "YES" or "NO" as it relates to your personal past medical history.

	Y	N		Y	N		Y	N
Alcoholism			Diverticulitis			Nervous Breakdown		
Anemia			Emphysema			Osteoporosis		
Arthritis			Gall Bladder Disease			Peptic Ulcers		
Asthma- Hay Fever			Glaucoma			Phlebitis		
Bleeding Disorder			Gout			Pneumonia		
Cancer			Heart Attack			Prostate Disease		
Cataracts			Heart Disease			Psoriasis- Eczema		
Chronic Bronchitis			Hemorrhoids			Rheumatic Fever		
Colitis (bowel inflammation)			Hepatitis			Seizures		
Crohn's Disease			Hernia			Epilepsy		
Depression			High Blood Pressure			Sinusitis		
Diabetes			High Cholesterol			Stroke		
Year of Diagnosis	______		Kidney Infections/Stones			Thyroid Disease		
Type 1 or Type 2	______		Other Kidney Disease			Tuberculosis		
Date of last eye exam	______		Mental Illness			Ulcerative Colitis		
Date of last foot exam	______		Migraine Headaches			Varicose Veins		
						Venereal Disease		

Please list all past surgeries with the estimated date of occurrence.

Surgery: Est. Date:

__________________ _____________

__________________ _____________

__________________ _____________

__________________ _____________

Please list all previous nonsurgical hospitalization(s) with the estimated dates of their occurrence.

Hospitalization: Est. Date:

____________________ _____________

____________________ _____________

____________________ _____________

____________________ _____________

Family Medical History: Please check each item in the box indicated "YES" or "NO" as it relates to your family medical history.

	Y	N		Y	N		Y	N		Y	N
Anemia			Depression			Other Heart Disease			Osteoporosis		
Arthritis			Diabetes			High Blood Pressure			Seizures- Epilepsy		
Asthma			Emphysema			Kidney Disease			Stomach Ulcers		
Bleeding Disorder			Glaucoma			Mental Illness			Stroke		
Cancer			Heart Attack			Migraine Headaches			Thyroid Disease		
									Tuberculosis		

Relative	If Living		If Deceased		Relative	If Living		If Deceased	
	Age	Health	Age of Death	Cause of Death		Age	Health	Age of Death	Cause of Death
Father Mother Brother & Sister					Children				

Reviewed by: ___________________________________ Date: _________________________