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.
(or provide list if you have one)

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 (×) all that apply.

□ Acid Reflux Disease	□ Chemical Dependency	□ High Chol./High Triglycerides	□ Pneumonia
□ Alcoholism	□ Depression	□ HIV Disease	□ Polio
□ Anemia	□ Diabetes	□ Irregular Menstrual Periods	□ Prostate Problem
□ Anorexia	□ Emphysema	□ Kidney Disease	□ Psychiatric Care
□ Arthritis	□ Epilepsy	□ Liver Disease	□ Stroke
□ Asthma/Lung Problem	□ Glaucoma	□ Migraine Headaches	□ Suicide Attempt
□ Bleeding Disorders	□ Goiter	□ Miscarriage	□ Thyroid Problems
□ Breast Lump	□ Gout	□ Multiple Sclerosis	□ Tuberculosis
□ Bulimia	□ Heart Disease	□ Mumps	□ Ulcers
□ Cancer	□ Hepatitis	□ Osteoporosis/Osteopenia	□ Vaginal Infections
□ Cataracts	□ High Blood Pressure	□ Pacemaker	

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

(All information is strictly confidential.)

PLEASE SEE OTHER SIDE

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.

GENERAL
☐ Fever
☐ Chills
☐ Sweats
☐ Loss of appetite
☐ Excessively tired
☐ Discomfort
☐ Weight loss
☐ Weight gain

EYES
☐ Blurring
☐ Double vision
☐ Irritation
☐ Discharge
☐ Vision loss
☐ Eye pain
☐ Intolerance of light
☐ Swelling

EARS/NOSE/THROAT
☐ Earache
☐ Ear discharge
☐ Ringing/Buzzing in ears
☐ Loss of hearing
☐ Nasal Congestion
☐ Nosebleeds
☐ Sore Throat
☐ Hoarseness
☐ Difficulty swallowing

CARDIOVASCULAR
☐ Chest pain/pressure
☐ Irregular heart beat
☐ Loss of consciousness
☐ Shortness of breath
☐ Swelling of ankles
☐ Varicose veins

RESPIRATORY
☐ Cough
☐ Shortness of breath
☐ Coughing up sputum
☐ Coughing up blood
☐ Wheezing
☐ Snoring

GASTROINTESTINAL
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Change in bowel habits
☐ Stomach pain
☐ Rectal bleeding/bloody stools
☐ Indigestion/Heart Burn
☐ Excessive gas

GENITO-URINARY

WOMEN ONLY
☐ Vaginal discharge
☐ Poor bladder control
☐ Painful urination
☐ Blood in urine
☐ Frequent urination
☐ Absent menstrual period
☐ Irregular menstrual period
☐ Decreased sex drive
☐ Pelvic pain ☐ Breast lump

MEN ONLY
☐ Painful urination
☐ Blood in urine
☐ Frequent urination
☐ Poor bladder control
☐ Erection difficulties
☐ Decreased sex drive
☐ Breast lump

MUSCULOSKELETAL
☐ Back pain
☐ Joint pain
☐ Muscle cramps
☐ Muscle weakness
☐ Stiffness
☐ Arthritis

SKIN
☐ Rash
☐ Itching
☐ Dryness
☐ Suspicious wounds

NEUROLOGIC
☐ Temporary paralysis
☐ Weakness ☐ Tremors
☐ Seizures ☐ Dizziness
☐ Loss of Consciousness
☐ Numbness/Tingling
☐ Headache

PSYCHIATRIC
☐ Depression
☐ Anxiety ☐ Paranoia
☐ Memory loss
☐ Mental disturbance
☐ Suicide thoughts
☐ Hallucinations

ENDOCRINE
☐ Cold intolerance
☐ Heat intolerance
☐ Frequent thirst
☐ Increased hunger
☐ Increased urination
☐ Weight loss or gain

HEME/LYMPHATIC
☐ Abnormal bruising
☐ Bleeding ☐ Enlarged lymph nodes

ALLERGIC/IMMUNOLOGIC
☐ Skin conditions ☐ Hay fever
☐ Persistent infections ☐ HIV exposure