Wichita Diabetes & Endocrinology LLC

Name:_____ Birth date:____/____/____ Date:____/____/____

What problems would you like to address today?: _____

When did this problem first start?: _____

Do you currently have?:

Change in Appetite:	Y _____	Diarrhea:	Y _____
Fatigue:	Y _____	Problem swallowing:	Y _____
Weight gain:	Y _____	Nausea/or Vomiting:(circle)	Y _____
Weight loss:	Y _____	Muscle cramps:	Y _____
Double vision:	Y _____	Joint pain	Y _____
Change in your voice:	Y _____	Easy bruising:	Y _____
Sensitivity to hot/or cold(circle):	Y _____	Stretch Marks:	Y _____
Low sex drive:	Y _____	Skin changes:	Y _____
Excessive sweating:	Y _____	Excess body hair:	Y _____
Excessive thirst:	Y _____	Skin rash:	Y _____
Excessive urination:	Y _____	Dizziness/ Fainting spells(circle):	Y _____
Hair loss:	Y _____	Headaches:	Y _____
Hot flashes	Y _____	Loss of sensation	Y _____
Snoring at night:	Y _____	Tingling in extremities:	Y _____
Shortness of breath:	Y _____	Shaking hands:	Y _____
Breast discharge:	Y _____	Mood swings:	Y _____
Swelling:	Y _____	Depression/or Anxiety(circle):	Y _____
Chest pain:	Y _____	Problem staying asleep:	Y _____
Heart racing:	Y _____	Daytime sleepiness:	Y _____
Constipation:	Y _____	Other:_____	

Current medications:

_____

_____

_____

_____

Medical History:

Have you ever been diagnosed with:

Diabetes	N	Y	_____
Thyroid disease	N	Y	_____
Heart Disease	N	Y	_____
Kidney disease	N	Y	_____
High Blood pressure	N	Y	_____
High Cholesterol	N	Y	_____
Sleep apnea	N	Y	_____
Osteoporosis	N	Y	_____
Pituitary disorder	N	Y	_____

Other:_____

Have you ever had(explain):

Major Head trauma:	N	Y	_____
Radiation exposure:	N	Y	_____
Radioactive Iodine:	N	Y	_____
Bone Fracture:	N	Y	_____
Kidney stone:	N	Y	_____
Seizure:	N	Y	_____

Any allergies(drug, food, other):

_____

Please complete the back of this form

List any surgeries/operation/procedures:

_____ _____

_____ _____

_____ _____

Please mark an (X) for family medical history:

	Diabetes Denote Type 1 or 2	High Blood pressure	Heart Disease	Cancer	Thyroid disease	High Cholesterol	Osteoporosis	Hip Fracture	Kidney stones	Hormone disorder	Brain tumor	Adrenal Tumor
Father												
Mother												
Sibling												
Daughter/Son												

Other, please specify: _____

Date of last dilated eye exam:(month/year)_____ **Social Status:** Single, Married, Widowed.

For Women Only:

Age period started:_____
Regular periods: N Y every _____days
Last period date_____
Vaginal dryness/discharge N Y
Check your breasts monthly N Y

Number of pregnancies _____Live birth___
Miscarriage/abortion_____
Number of children _____Ages_____
Last Pap smear and result_____
Please circles if there is increase hair growth on:
Face Chest/Breast Back Abdomen Inner thighs

Last mammogram/Breast exam_____
Last Bone density scan(Dexascan)_____

For Men Only:

Last Testicular exam: _____
Last Prostate exam:_____
Last Bone density scan_____

Do you have Biological children: Y N
Do you have problem urinating? _____

Immunization:

Flu Shot: N Y Date:_____
Pneumonia shot: N Y Date:_____
Shingles shot: N Y Date:_____
Hepatitis B shot: N Y Date:_____

Social History

Do you smoke: No Yes
Amount per day(pack)_____

What type: Cigarettes, Cigar, Chew, Pipe.
How long have you used tobacco?:_____

Former smoker or tobacco user: Quit date:_____
How long did you use tobacco?_____

What type: Cigarettes, Cigar, Chew, Pipe.

Do you Drink Alcohol?: No Yes
How many drinks per week?:_____

What type:_____

Ever used(mark with (X)): Marijuana_____ **Cocaine**_____ **Heroin**_____ **Speed**_____ **IV drugs**_____
Ever used performance drugs?: No Yes If Yes, what type: _____

Occupation:_____