Name:	DOB :	Age:
Reason for visit:		

I have had the following medical conditions, treatments, and surgeries:	Date of diagnosis

I take the following medications:

Name of medication	Dose	How often	Date started

Allergies: (please list type of reaction i.e. rash, difficulty breathing, swelling of face etc.)

Family history: Mother (m), Father (f), sister (s), brother (b), daughter (d), Son (sn). Please check.

	m	f	s	b	d	sn	Deceased	Age
High cholesterol							Y / N	
Heart disease							Y / N	
Stroke							Y / N	
Cancer (pleases specify)							Y / N	
Type 1 Diabetes							Y / N	
Type 2 Diabetes							Y / N	
High blood pressure (hypertension)							Y / N	
Hyperthyroidism / Hypothyroidism							Y / N	

Other (please specify)													***Y / N***		
Please indicate if you have had any of the following:															
Fatigue		Easy bruising		Slow Stream		Seizures	
Malaise		Easy bleeding		Increased urinary frequency		Tremors	
Hot flushes		Back pain		Urinary retention		Anxiety	
Weight gain lbs.		Joint/bone pain		Increased thirst		Depression	
Weight loss lbs.		Water retention		Erectile dysfunction		Insomnia	
Ear pain		Chest pain		Vaginal dryness		Brittle hair	
Ear discharge		Pain in calves when walking		Sexual dysfunction		Brittle nails	
Hearing loss		Palpitations		Excessive hair growth		Rash	
Sinus pressure		Abdominal pain		Hair loss		Skin lesion	
Sore throat		Constipation		Cold intolerance		Muscle weakness	
Blurred vision		Diarrhea		Heat intolerance		Food Allergy	
Double vision		Heartburn		Difficulty swallowing		Seasonal Allergy	
Eye pain		Loss of appetite		Changes in your voice		Other	
Cough		Nausea		Dizziness		Other	
Known TB exposure		Vomiting		Numbness		Other	
Shortness of breath		Dribbling when urinating		Headaches		Other	
Wheezing		Pain when urinating		Memory loss		Other:	

Smoking history: # of packs/day # of years Quit date: / /

Alcohol use: # of drinks per day/week/ month

Vaccination: Flu Date / / Pneumonia Date / / Tetanus Date / /

For women:

Age of 1st menstrual period	Date Last menstrual period	No. of Pregnancies	Regular periods	Miscarriages	Abortions
			Y / N	Y /N #	Y /N #

Have you had gestational diabetes? Y / N

For patients with Diabetes: Type 1 / 2 Date of diagnosis: / / A1C_____ % Date: / /

Basal insulin: Lantus / Levemir / Toujeo / Tresiba / NPH	AM dose units	PM dose units

Mealtime insulin: Humalog / Novolog / Apidra / Afrezza / Regular

Dose (units):	Breakfast	Lunch	Dinner	Bedtime

For pump users:	Name of pump	Basal rate 1 From: To: u/h	Basal rate 2 From: To: u/h	Basal rate 3 From: To: u/h	Basal rate 4 From: To: u/h

Correction factor:	Sensitivity:	Active insulin time:	
Last dilated eye exam / /	Retinopathy: Y /N (PR /NPR)	Glaucoma Y / N	Cataract Y / N

I certify that the above is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____