LABEL

THE UNIVERSITY OF KANSAS PHYSICIANS

DIVISION OF METABOLISM, ENDOCRINOLOGY AND GENETICS

CRAY DIABETES CENTER, HIATT OSTEOPOROSIS CLINIC

Leland Graves, III, M.D., Division Director, David C. Robbins, M.D. Director, Cray Diabetes Center and KU Diabetes Institute
Rajib Bhattacharya, M.D, Leigh Eck, M.D. Candice Rose, M.D. Rudruidee Karnchanasorn, M.D. Ioannis Papagiannis, M.D. John Miles, M.D.
Endocrinology Fellows: Kristin Grdinovac, M.D. Mark Oertel, M.D. Abeer Anabtawi, M.D.
Andrea Dohlman., A.R.N.P. Teri Lavenbarg, A.R.N.P. Kerstin Stephens, M.H.S, P.A.-C
Emily Newbold, R.D.

PERSONAL HEALTH HISTORY INFORMATION			
Name (Last, First, Middle)		**Date of Birth**	☐ **Female** ☐ **Male**
Reason for your visit:			

SOCIAL HISTORY

Marital Status	☐ Single	☐ Partnered	☐ Separated
	☐ Married	☐ Divorced	☐ Widowed
Employment	☐ Occupation:	☐ Homemaker	☐ Student
	☐ Retired	☐ Disabled	☐ Unemployed

Tobacco	☐ NO – I do not smoke and have never smoked		
	☐ YES – I previously smoked but no longer smoke	Quit Date:	
		Previous # packs/day	
		Total years smoked	
	☐ YES – I am currently smoking	# packs/day	
		# years smoking	
	Do you use chewing tobacco? ☐YES ☐NO ☐QUIT Date ________________		

ALLERGIES: Allergies or Adverse Reactions to medication so or other substances – please list drug name w/ reaction

MEDICATIONS: List your prescribed drugs, over-the-counter, vitamins and supplements OR BRING YOUR OWN CURRENT LIST

Name	Strength (20 mg, units, cc's)	Frequency (1x a day….)

PHARMACY: Please enter in the information regarding the pharmacy you would like prescriptions sent to

Name:	**Address:**
Phone Number:	

FLIP OVER FOR ADDITIONAL QUESTIONS

MEDICAL HISTORY: Please list all your medical conditions and diagnoses below:	

SURGERIES		
Year	**Surgery**	**Hospital**

FAMILY HEALTH HISTORY (Please fill in for those members with whom you are familiar)

Are you adopted ☐ YES ☐ NO IF YOU ARE ADOPTED, PLEASE REFER TO YOUR BIOLOGICAL PARENTS, IF KNOWN

	Living/Deceased	Age	Significant Health History
Mother			
Father			

Please list any other significant medical conditions that run in any other family members here	

Alcohol			
	☐ NO – I do not drink any alcohol		
	☐ YES – I previously drink but no longer drink alcohol	Quit Date	
		Type of alcohol	
		# drinks/week	
	☐ YES – I drink alcohol	Type of alcohol	
		# of drinks/week	

VACCINATIONS: Please list the date of your last vaccine for the following:			
Influenza (flu):		**Tetanus:**	
Pneumonia :		**Shingles :**	

Your Providers: Please enter the name of your following providers:	
Referring Physician:	
Primary Care Physician:	

HOSPITALIZATIONS		
Year	**Reason**	**Hospital**

MyChart offers secure on-line access to portions of your electronic medical record, where your doctor stores your health information. It allows you to communicate with your care team via secure messaging when it is convenient for you.

Would you like access to the myChart website? ☐ YES ☐ NO

Welcome to the Cray Diabetes Center! In order to make the most of your visit, please answer the following questions before your visit. ***Remember to bring your meter to clinic with you!***

- What are your goals for today's visit? ____
- In terms of your health, please complete the sentence: I wish I could___________________________
- On average, how often do you check your blood sugar? _____________________________________
    - What is your blood sugar target before meals? _____________
- What are the usual blood sugars readings:

  before breakfast_______ before lunch_______ before dinner________ before bedtime_______
- What meter reading do you start feeling symptoms of low blood sugars? _______________________
- How often do you have low blood sugars (less than 70 mg/dL)? ______________________________
- What time of day do you usually have low blood sugars? ____________________________________
- What symptoms do you have with low blood sugars? _______________________________________
- How many times in the last 3 months have you experienced the above symptoms? ______________
- Have you ever had sugars so low that you couldn't treat them on your own? ☐No ☐Yes
- What do you use to treat a low blood sugar? ____
- Do your friends and family know how to recognize and treat a low blood sugar? ☐No ☐Yes

Do you wear a medical ID bracelet/necklace?	☐ No	☐ Yes
Do you keep a source of sugar on hand at all times?	☐ No	☐ Yes
Do you have a glucagon emergency kit?	☐ No	☐ Yes Is it expired? _____
Do you check for ketones when you are sick?	☐ No	☐ Yes
Are you happy with your current meal plan?	☐ No	☐ Yes
Would you like to meet with a dietitian nutritionist?	☐ No	☐ Yes

Do you exercise? ☐ No ☐ Yes Type: ________________________________

How often do you exercise? ___ times per week. How long does the activity usually last? ____minutes

Please take a moment to answer the general health questions on the back of this form as well.

PLACE AN X IN ANY BOX NEXT TO A PROBLEM OR DISTRUBANCE YOU HAVE HAD IN THE PAST YEAR			
GENERAL HEALTH ☐ No problems	☐ Weight loss ☐ Night sweat ☐ Hot flashes	☐ Weight gain ☐ Heat sensitivity ☐ Cold sensitivity	☐ Loss of appetite ☐ Tire easily ☐ Weakness
SKIN/HAIR/NAILS ☐ No problems **Last foot exam:** _________	☐ Skin rash ☐ Excessive sweating ☐ Foot callus	☐ Dry Skin ☐ Skin itching ☐ Foot sore or ulcer	☐ Change in hair/nails ☐ Non healing wounds ☐ Excessive facial hair
EYES ☐ No Problems	**Date of last eye exam:** _____________________	☐ Eye redness ☐ Peripheral vision loss	☐ Eye pain ☐ Double vision
EARS/NOSE ☐ No problems	☐ Ringing in the ears ☐ Decrease in hearing	☐ Discharge from ears ☐ Loss/lack of smell	☐ Ear pain
MOUTH ☐ No problems	**Date of last dentist visit:** ____________________	☐ Bleeding gums ☐ Dental infection ☐ Recent tooth extraction	☐ Dental implants ☐ Dental surgery
NECK ☐ No problems	☐ Neck swelling or lumps ☐ Persistent hoarseness	☐ Neck stiffness ☐ Food getting stuck	☐ Sore throat
CHEST ☐ No problems	☐ Frequent cough ☐ Bloody sputum	☐ Wheezing ☐ Painful breathing	☐ Shortness of breath ☐ Chest pain/discomfort
HEART ☐ No problems	☐ Swelling of hands/feet ☐ Blood clots	☐ Palpitations ☐ Enlarged veins	☐ Irregular heartbeat
STOMACH/BOWELS ☐ No problems	☐ Abdominal cramping ☐ Chronic constipation ☐ Heartburn	☐ Nausea/Vomiting ☐ Rectal bleeding ☐ Gastric reflux	☐ Chronic diarrhea ☐ Black tarry stools
URINARY ☐ No problems	☐ Frequent urination ☐ Leakage of urine	☐ Increase in thirst ☐ Difficulty urinating	☐ Painful urination ☐ Kidney stone history
GENITAL ☐ No problems	☐ Lack of sex drive	☐ Painful sex	
NEURO ☐ No problems	☐ Numbness/tingling ☐ Memory loss ☐ Loss of balance	☐ Tremors ☐ Dizziness ☐ Trouble with anxiety	☐ Headaches ☐ Depression ☐ Sleep problems/changes
MUSCLES/BONE/JOINTS ☐ No problems	☐ Back pain ☐ Muscle cramps/spasms	☐ Joint pain or stiffness ☐ Swollen joints	☐ History of broken bones:_______________ ____________________
MEN ONLY ☐ No problems	☐ Difficulty with erection	☐ Testicle lump/pain	☐ Penis discharge
WOMEN ONLY ☐ No problems	☐ Period absent ☐ Menstrual pain/cramps ☐ Breast discharge ☐ Menopause Age: ___________	☐ Irregular menstrual cycle ☐ Breast Pain Date of last mammogram: ______________________	☐ Heavy menstrual flow ☐ Hormone replacement therapy # of pregnancies: _______ # of live births: _________
MENTAL HEALTH ☐ No problems	☐ Do you often feel overwhelmed by your disease?	☐ Are there very few things that make you happy?	If so, Explain:

Anything else you would like your provider to know: