

**DIVISION OF METABOLISM, ENDOCRINOLOGY AND GENETICS  
CRAY DIABETES CENTER, HIATT OSTEOPOROSIS CLINIC**

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**PERSONAL HEALTH HISTORY INFORMATION**

<b>Name (Last, First, Middle)</b>	<b>Date of Birth</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male
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**Reason for your visit:**

**SOCIAL HISTORY**

<b>Marital Status</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Separated
	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed

<b>Employment</b>	<input type="checkbox"/> Occupation:			
	<input type="checkbox"/> Retired	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Student	<input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed

<b>Tobacco</b>	<input type="checkbox"/> NO – I do not smoke and have never smoked		
	<input type="checkbox"/> YES – I previously smoked but no longer smoke	Quit Date:	
		Previous # packs/day	
		Total years smoked	
	<input type="checkbox"/> YES – I am currently smoking	# packs/day	
	# years smoking		
Do you use chewing tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> QUIT Date _____			

<b>Alcohol</b>	<input type="checkbox"/> NO – I do not drink any alcohol		
	<input type="checkbox"/> YES – I previously drink but no longer drink alcohol	Quit Date	
		Type of alcohol	
		# drinks/week	
	<input type="checkbox"/> YES – I drink alcohol	Type of alcohol	
	# of drinks/week		

**ALLERGIES: Have your medication allergies changed since your last visit?**


**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....)

**FLIP OVER FOR ADDITIONAL QUESTIONS**

**PHARMACY: Has your pharmacy changed since your last visit?**  YES  NO If so, please update below

<b>Name:</b>	<b>Address:</b>
<b>Phone Number:</b>	

**HOSPITALIZATIONS OR NEW MEDICAL PROBLEMS SINCE YOUR LAST VISIT**


**SURGERIES OR PROCEDURES SINCE YOUR LAST VISIT**

<b>Date</b>	<b>Surgery</b>	<b>Hospital</b>

**VACCINATIONS: Please list the date of your last vaccine for the following:**

<b>Influenza (flu):</b>		<b>Tetanus:</b>	
<b>Pneumonia :</b>		<b>Shingles :</b>	

**Your Providers: Please enter the name of your following providers:**

<b>Referring Physician:</b>	
<b>Primary Care Physician:</b>	

PLACE AN **X** IN ANY BOX NEXT TO A PROBLEM OR DISTURBANCE YOU HAVE HAD IN THE PAST YEAR

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

Anything else you would like your provider to know: