THE UNIVERSITY OF KANSAS PHYSICIANS

DIVISION OF METABOLISM, ENDOCRINOLOGY AND GENETICS

CRAY DIABETES CENTER, HIATT OSTEOPOROSIS CLINIC

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LABEL

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:				
	☐ Retired	☐ Homemaker	☐ Student	☐ 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 _____		
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	

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	
Name:	**Address:**
Phone Number:	

HOSPITALIZATIONS OR NEW MEDICAL PROBLEMS SINCE YOUR LAST VISIT	

SURGERIES OR PROCEDURES SINCE YOUR LAST VISIT		
Date	**Surgery**	**Hospital**

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:	

Welcome back to the Hiatt Osteoporosis Clinic. In order to maximize your visit, please take time to answer the following questions prior to your visit.

Question	Answer	Explain
Have you had any fractures (broken bones) since your last visit?	☐ No ☐ Yes	
Have you fallen down in the last 6 months?	☐ No ☐ Yes	
Are you experiencing any issues with your balance or gait?	☐ No ☐ Yes	
Are you having any hip, pelvic or thigh pain?	☐ No ☐ Yes	
Are you doing any regular exercise?	☐ No ☐ Yes	
Do you have any loose or bothersome teeth?	☐ No ☐ Yes	
Do you anticipate needing to have a tooth pulled or any invasive dental work in the near future?	☐ No ☐ Yes	
Are you experiencing heartburn or stomach pain?	☐ No ☐ Yes	
Do you have trouble with food getting stuck after swallowing?	☐ No ☐ Yes	
Have you required and prednisone, hydrocortisone or other steroid medication either by mouth or injection (joint injection) since your last visit?	☐ No ☐ Yes	
Do you take calcium tablets?	☐ No ☐ Yes	
How many dairy servings do you eat on an average day (1 cup of milk, an ounce of cheese, yogurt cup)?		
When is the last time you saw a dentist?		

Do you have any other specific additional concerns to review at today's visit? _____

_____

_____

_____

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: