DIABETES CARE CENTER

QUESTIONNAIRE

Name: _____ Date: _____

Date of last physical exam:

Is this a routine check-up? ❑ YES ❑ NO If no, list all symptoms you have now...

1. _____
2. _____
3. _____
4. _____

RELATIVES	AGE	IF LIVING, HEALTH CONDITION	IF DECEASED, AGE OF DEATH	CAUSE
Father				
Mother				
Brother				
Sister				
Spouse				
Son				
Daughter				

HAS ANY BLOOD RELATIVE EVER HAD:	WHO:
Cancer: What kind?	
Tuberculosis:	
Diabetes:	
Heart trouble:	
High Blood Pressure:	
Stroke:	
Epilepsy:	
Insanity:	
Suicide:	
Thyroid Disease:	

PLEASE CONTINUE TO THE NEXT PAGE

PATIENT NAME _____ DATE _____

• ***CONSTITUTIONAL SYMPTOMS***			
Good general health lately	No	Yes	
Recent weight change	No	Yes	
Fever	No	Yes	
Fatigue	No	Yes	
Headaches	No	Yes	
• ***EYES***			
Eye disease or injury	No	Yes	
Wear glasses/contact lenses	No	Yes	
Blurred or double vision	No	Yes	
Glaucoma	No	Yes	
• ***EARS/NOSE/MOUTH/THROAT***			
Hearing loss or ringing	No	Yes	
Earaches or drainage	No	Yes	
Chronic sinus problem or rhinitis	No	Yes	
Nose bleeds	No	Yes	
Mouth sores	No	Yes	
Bleeding gums	No	Yes	
Bad breath or bad taste	No	Yes	
Sore throat or voice change	No	Yes	
Swollen glands in neck	No	Yes	
• ***CARDIOVASCULAR***			
Heart trouble	No	Yes	
Chest pain or angina pectoris	No	Yes	
Palpitation	No	Yes	
Shortness of breath with walking or lying flat	No	Yes	
Swelling of feet, ankles or hands	No	Yes	
• ***RESPIRATORY***			
Chronic or frequent cough	No	Yes	
Spitting up blood	No	Yes	
Shortness of breath	No	Yes	
Asthma or wheezing	No	Yes	
• ***GASTROINTESTINAL***			
Loss of appetite	No	Yes	
Change in bowel movements	No	Yes	
Nausea or vomiting	No	Yes	
Frequent diarrhea	No	Yes	
Painful bowel movements or constipation	No	Yes	
Rectal bleeding or blood in stool	No	Yes	
Abdominal pain	No	Yes	
Peptic ulcer (stomach or duodenal)	No	Yes	
• ***GENITOURINARY***			
Frequent urination	No	Yes	
Burning or painful urination	No	Yes	
Blood in urine	No	Yes	
Change in force of strain when urinating	No	Yes	
Incontinence or dribbling	No	Yes	
Kidney stones	No	Yes	
Sexual difficulty	No	Yes	
Male - testicle pain	No	Yes	
Female - pain with periods	No	Yes	
Female - irregular periods	No	Yes	
Female - vaginal discharge	No	Yes	
Female - # of pregnancies:			
Female - # of miscarriages:			
Female - date of last pap smear:			

• ***MUSCULOSKELETAL***			
Joint pain	No	Yes	
Joint stiffness or swelling	No	Yes	
Weakness of muscles or joints	No	Yes	
Muscle pain or cramps	No	Yes	
Back pain	No	Yes	
Cold extremities	No	Yes	
Difficulty in walking	No	Yes	
• ***INTEGUMENTARY (skin, breast)***			
Rash or itching	No	Yes	
Change in skin color	No	Yes	
Change in hair or nails	No	Yes	
Varicose veins	No	Yes	
Breast pain	No	Yes	
Breast lump	No	Yes	
Breast discharge	No	Yes	
• ***NEUROLOGICAL***			
Frequent or recurring headaches	No	Yes	
Light headed or dizzy	No	Yes	
Convulsions or seizures	No	Yes	
Numbness or tingling sensations	No	Yes	
Tremors	No	Yes	
Paralysis	No	Yes	
Stroke	No	Yes	
Head injury	No	Yes	
• ***PSYCHIATRIC***			
Memory loss or confusion	No	Yes	
Nervousness	No	Yes	
Depression	No	Yes	
Insomnia	No	Yes	
• ***ENDOCRINE***			
Glandular or hormone problem	No	Yes	
Thyroid disease	No	Yes	
Diabetes *(insulin or non insulin - circle one)*	No	Yes	
Excessive thirst or urination	No	Yes	
Heat or cold intolerance	No	Yes	
Skin becoming dryer	No	Yes	
Change in hat or glove size	No	Yes	
• ***HEMATOLOGIC/LYMPHATIC***			
Slow to heal after	No	Yes	
Bleeding or bruising tendency	No	Yes	
Anemia	No	Yes	
Phlebitis	No	Yes	
Past transfusion	No	Yes	
Enlarged glands	No	Yes	
• ***ALLERGIC/IMMUNOLOGIC***			
History of skin reaction or other adverse reaction to:			
Penicillin or other antibiotics	No	Yes	
Morphine, Demerol or other narcotics	No	Yes	
Novocain or other anesthetics	No	Yes	
Aspirin or other pain remedies	No	Yes	
Tetanus antitoxin or other serums	No	Yes	
Iodine, methiolate or other antiseptic	No	Yes	
Other drugs/medications	No	Yes	
Known food allergies:			
Environmental allergies:			

Patient Name: _____

PERSONAL HISTORY

Illnesses

Have you ever had any of the following: (please check next to the ones you've had or have)

- ❑ Measles: _____
- ❑ Mumps: _____
- ❑ Chickenpox: _____
- ❑ Epilepsy: _____
- ❑ Stroke: _____
- ❑ Glaucoma (Last eye exam): _____
- ❑ Cataract: _____
- ❑ Rheumatic Fever: _____
- ❑ Heart Disease: _____
- ❑ Congestive Heart Failure: _____
- ❑ Pneumonia: _____
- ❑ Asthma or Hay Fever: _____
- ❑ Emphysema/COPD: _____
- ❑ Tuberculosis: _____
- ❑ High Blood Pressure: _____
- ❑ Gallbladder Disease: _____
- ❑ Sleep Apnea: _____
- ❑ Hepatitis: _____
- ❑ Fatty Liver: _____
- ❑ Stomach or Duodenal Ulcer: _____
- ❑ Colon or Bowel Trouble/IBS: _____
- ❑ Kidney Disease: _____ ❑ Stage: _____
- ❑ Bladder: _____
- ❑ Anemia: _____
- ❑ Diabetes: _____
- ❑ Thyroid Disease: _____
- ❑ Thyroid Nodules/Goiter: _____
- ❑ Hives or Eczema: _____
- ❑ Nervous Breakdown: _____
- ❑ Depression: _____
- ❑ High Cholesterol: _____
- ❑ Cancer/Type: _____
- ❑ High Calcium: _____
- ❑ Pancreatitis: _____
- ❑ Osteoporosis: _____
- ❑ Low Testosterone: _____
- ❑ Polycystic Ovary Syndrome (PCOS): _____
- ❑ Any Other: _____

_____

Hospital

Have you ever been hospitalized for any illness, including surgery? *(Give details and dates.)*

_____

_____

_____

_____

_____

_____

Allergies

Are you allergic to any:

Drugs: _____

Foods: _____

Other: _____

Current Medications:

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____

Past Medications You Have Taken:

- ❑ Insulin: _____
- ❑ Thyroid: _____
- ❑ Blood Pressure Medication: _____
- ❑ Tranquilizers: _____
- ❑ Birth Control Pills: _____
- ❑ Hormone Pills: _____
- ❑ Other: _____

_____

PLEASE CONTINUE TO THE NEXT PAGE

Patient Name: _____

SOCIAL HISTORY

Have you ever smoked? ❑ NO ❑ YES Do you smoke now? ❑ NO ❑ YES How many per day? _____

If you quit, when?_____At what age did you start?_____

Do you drink alcoholic beverages? ❑ NO ❑ YES How much? _____

Are you on a special diet? ❑ NO ❑ YES If yes, what kind of diet? _____

Your weight now:_____One year ago:_____

States and countries in which you have lived?_____

When did you move to florida? _____

Previous occupations:_____

Have you ever had an EKG? ❑ NO ❑ YES If yes, date of last one: _____

Have you ever had a chest x-ray? ❑ NO ❑ YES If yes, date of last one:_____

DEVICES

Do You Use...?

Eyeglasses..... ❑ NO ❑ YES Hearing Aids..... ❑ NO ❑ YES IUD..... ❑ NO ❑ YES

Contact Lenses..... ❑ NO ❑ YES Dentures ..... ❑ NO ❑ YES Others_____

WOMEN

Menstrual History:

Age at onset:_____ ❑ Regular or ❑ Irregular Last menstrual period: _____

Date of last pap smear or pelvic exam: _____

Have you ever had an mammography? ❑ NO ❑ YES If yes, date of last one:_____

Pregnancy:

How many times pregnant?_____ Full term:_____ Premature: _____

Abortions: Spontaneous:_____ Therapeutic: _____

Living children:_____ Birth defects: _____

Any complications with pregnancy? _____

Date of last childbirth: _____

Any other information you would like to list:_____

_____

_____

_____

_____

_____

Doctor's Initials:_____