UPMC LIFE CHANGING MEDICINE

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Center for Diabetes and Endocrinology

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NEW PATIENT HISTORY FORM

NAME _____ REFERRING PHYSICIAN _____

Date of birth _____ Main Occupation/Employment _____

Reason for today's visit _____

_____.

List surgical procedures Medications/Dose

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical Conditions Allergies

_____ _____

_____ _____

_____ _____

_____ _____

Smoking _____ No _____ Quit When did you stop? _____

_____ Yes _____ # of cigarettes per day

Alcohol _____ No _____ Quit

_____ Yes _____ # of drinks per day Type of alcohol _____

Planned Exercise _____ No _____ Yes

If yes, what exercise? _____

How often? _____

How long? _____

Check all that apply to you and explain briefly:

_____ Diabetes _____ _____ Kidney disease_____

_____ Skin problems _____ _____ Osteoporosis/bone disease_____

_____ High blood pressure _____ _____ Heartburn _____

_____ Heart disease _____ _____ Liver disease _____

_____ Arthritis _____ _____ Anemia _____

_____ Thyroid disease _____ _____ Neurologic disease _____

_____ Cancer _____ _____ Blood clots _____

_____ Stomach ulcers _____ _____ Seizures _____

_____ Other medical problems: _____ Headaches _____

_____ Height Loss _____ Tallest Adult Height _____ Told that you snore _____

_____
_____.

Family History: Type of disorder and family relationship Relationship

_____ Diabetes _____ _____

_____ Thyroid disease _____ _____

_____ Heart disease _____ _____

_____ Hypertension _____ _____

_____ Stroke _____ _____

_____ Cancer _____ _____

_____ Cholesterol or lipid disorder _____ _____

_____ Osteoporosis _____ _____

_____ Abnormal calcium _____ _____

_____ Kidney stones _____ _____

_____ Pituitary or adrenal tumor _____ _____

_____ Other _____ _____

Mother --- Living _____ Yes _____ No Medical problems _____

Father – Living _____ Yes _____ No Medical problems _____

REVIEW OF SYSTEMS

How are you feeling today? _____

Please check Yes or No for each:

General Health	**Yes**	**No**
Good general health	___	___
Weight gain	___	___
Weight loss	___	___
Excessive fatigue	___	___
Excessive thirst	___	___

Eyes	**Yes**	**No**
Blurred vision	___	___
Double vision	___	___

Respiratory	**Yes**	**No**
Shortness of breath	___	___
Cough	___	___

Cardiovascular	**Yes**	**No**
Palpitations (heart racing)	___	___
Irregular heart rate	___	___
Chest pain	___	___
Ankle swelling	___	___

Gastrointestinal	**Yes**	**No**
Nausea	___	___
Vomiting	___	___
Diarrhea	___	___
Constipation	___	___
Abdominal pain	___	___
Blood in stool	___	___

Skin	**Yes**	**No**
Hair loss	___	___
Change in nails	___	___
Excessive sweating	___	___

Musculoskeletal	**Yes**	**No**
Pain in joints	___	___
Back pain	___	___
Swelling in joints	___	___
Recent fractures	___	___

Neurological	**Yes**	**No**
Weakness	___	___
Numbness	___	___
Burning	___	___
Pins & needles	___	___
Tremor	___	___
Headaches	___	___

Psychiatric	**Yes**	**No**
Anxiety	___	___
Depression	___	___
Sleep disturbances	___	___

Reproductive	**Yes**	**No**
Sexual problems	___	___
Low sex drive	___	___

Genitourinary	**Yes**	**No**
Frequent urination	___	___
Nighttime urination	___	___
(how often/night)	_____	
Blood in urine	___	___
Poor urine control	___	___

For Women Only	**Yes**	**No**
Are you still having periods	___	___
Regular?	___	___
If yes: Length of cycle	_____	
In no: Age of menopause	_____	
Estrogen therapy	___	___
Abnormal hair growth	___	___
Discharge from breast	___	___

FOR PATIENTS WITH DIABETES ONLY

Duration of diabetes _____ Age at onset _____

Current treatment regimen Oral agents: _____

Insulin: _____

Do you have a glucose meter? _____ Yes _____ No

How often do you check glucoses? _____

Any complications with your diabetes (check all that apply)

_____ Eye problems _____ Laser treatments _____ Date of last eye exam

_____ Kidney problems

_____ Nerve damage _____ Foot ulcer (date -- _____)

_____ Heart attack _____ Bypass surgery (date -- _____)

_____ Angioplasty (date -- _____)

Most recent stress test _____