CENTER FOR DIABETES, ENDOCRINOLOGY & NUTRITION, INC

PERSONAL HEALTH HISTORY INFORMATION

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name (First, MI, Last): | Date: | Date of Birth:

Reason for referral to our practice:

MEDICAL HISTORY

☐ High Blood Pressure	☐ Heart Trouble	☐ Diabetes	☐ Asthma, Hay Fever
☐ High Cholesterol	☐ Diabetes	☐ Thyroid Disorder	☐ Pneumonia

□ Other past or current medical condition:

Surgeries:

Hospitalizations/Major Injuries:

Significant health conditions of your family members:

MEDICATIONS

List your medications, including: prescribed drugs, birth control, pain medication, sleep aids, over-the-counter vitamins and supplements. (Include name, strength, frequency taken)

List Allergies or Adverse Reactions to medications or other substances below: (Include drug name and allergic reaction)

SOCIAL HISTORY

What do you do for exercise?

What do you do for relaxation?

What methods do you use to control your weight?

Do you use: (Place an X in the box next to those you use)

☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Beer ☐ Wine ☐ Hard liquor ☐ Recreational drugs

SEXUAL/MENSTRUAL HISTORY

Are you sexually active? | Are you using birth control? Which type?

When was your last period? | Are you trying to become pregnant?