THE UNIVERSITY OF KANSAS PHYSICIANS

DIVISION OF METABOLISM, ENDOCRINOLOGY AND GENETICS

CRAY DIABETES CENTER, HIATT OSTEOPOROSIS CLINIC

Leland Graves, III, M.D., Division Director, David C. Robbins, M.D. Director, Cray Diabetes Center and KU Diabetes Institute
Rajib Bhattacharya, M.D, Leigh Eck, M.D. Candice Rose, M.D. Rudruidee Karnchanasorn, M.D. Ioannis Papagiannis, M.D. John Miles, M.D.
Endocrinology Fellows: Kristin Grdinovac, M.D. Mark Oertel, M.D. Abeer Anabtawi, M.D.
Andrea Dohlman., A.R.N.P. Teri Lavenbarg, A.R.N.P. Kerstin Stephens, M.H.S, P.A.-C
Emily Newbold, R.D.

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:	

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: