LABEL

THE UNIVERSITY OF KANSAS PHYSICIANS

DIVISION OF METABOLISM, ENDOCRINOLOGY AND GENETICS

CRAY DIABETES CENTER, HIATT OSTEOPOROSIS CLINIC

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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:	☐ Homemaker	☐ Student	
	☐ Retired	☐ 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: Allergies or Adverse Reactions to medication so or other substances – please list drug name w/ reaction	

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: Please enter in the information regarding the pharmacy you would like prescriptions sent to

Name:	Address:
Phone Number:	

MEDICAL HISTORY: Please list all your medical conditions and diagnoses below:	

SURGERIES		
Year	Surgery	Hospital

FAMILY HEALTH HISTORY (Please fill in for those members with whom you are familiar)			
Are you adopted ☐YES ☐NO IF YOU ARE ADOPTED, PLEASE REFER TO YOUR BIOLOGICAL PARENTS, IF KNOWN			
	Living/Deceased	Age	Significant Health History
Mother			
Father			
Please list any other significant medical conditions that run in any other family members here			

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:	

Would you like access to the myChart website? ☐YES ☐NO

HOSPITALIZATIONS		
Year	Reason	Hospital

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: