Diabetes & Endocrinology Specialists, Inc.

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Board Certified in Internal Medicine
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NEW PATIENT HISTORY

(PLEASE ANSWER ALL QUESTIONS)

Name: _____ **DOB:** _____ **Date:** _____.

Referring Physician: _____.

Referring Physician's Phone #: _____ **Fax #, if known:** _____.

Chief Complaint: _____.

_____.

_____.

_____.

_____.

_____.

_____.

Past Medical History

Diabetes: _____ _____

High Blood Pressure: _____ _____

High Cholesterol: _____ _____

Thyroid Disease: _____ _____

Osteoporosis: _____ _____

Heart Disease (specify): _____ _____

Obesity: _____ _____

Others: _____ _____

Surgeries: _____

_____

Medications (including over-the-counter)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Allergies: Meds – _____ Latex: ☐ Yes ☐ No

OVER

Social History

Occupation: _____ Are you? Single ☐ Divorced ☐ Widow ☐ Married ☐
Tobacco use (cigarettes/daily): _____Years of use: _____ Stop date: _____
Alcohol use (specify amount): _____ Coffee: _____ Street drugs: _____

Family History (parents, siblings, grandparents, children)

Diabetes: _____
High Blood Pressure: _____
High Cholesterol: _____
Heart Disease: _____
Thyroid Disease: _____
Others: _____

Do you exercise? ☐ Yes ☐ No If yes, how often? _____
Diet: _____ Weight History: _____

Last ophthalmologic exam (eye doctor): _____
Diabetic Education (If applicable)? ☐ Yes ☐ No If yes, when? _____

ROS:		Yes	No
Const.	Fever		
	Unintentional Weight Changes		
	Fatigue		
	Difficulty Sleeping		
Eyes	Visual Disturbances (specify)		
	Abnormal Peripheral vision		
ENT	Hearing		
	Difficulty Swallowing		
	Hoarseness		
Resp/CV	Chest pain		
	Shortness of Breath (if so, when)?		
	Heart Pounding		
	Lightheadedness		
	Leg swelling		
	Cough		
GI	Nausea/Vomiting		
	Diarrhea		
	Constipation		
GU	Problems with urination		
Neuro	Numbness		
	Weakness		
Breasts	Discharge		
	Masses		
Musc/Skel	Pain		
	Anxiety		
	Depression		
Other			
Women Only	Regular Periods		
	Post Menopausal		

OVER