Endocrinology, Diabetes, & Lipid Clinic

History Questionnaire – Fill out in BLACK ink

Name: _____ Date of Birth: _____

Date: _____ Race: _____

GENDER: Male Female Height (inch): _____ Weight (lbs) _____

AGE: _____ FAX#: _____ E-mail: _____

PHONE (Home): _____ (Cell): _____

With which of your doctors would you like us to communicate? NONE

Name:	Address:	Room:	City:	State:	ZIP:

What is your occupation? _____ Employer: _____

What issues would you like to discuss during your office visit?

Do you have high cholesterol or triglycerides? **YES NO UNKNOWN**

If YES: What was elevated? **Cholesterol** **Triglycerides** **Both** (circle one)

What is the highest cholesterol that you have had? _____ Triglycerides? _____

What medications have you taken for this condition? _____

_____

Have you had any reactions to these medications? **YES NO**

What type of reaction(s) have you had? _____

_____

_____

What has been your best Cholesterol level? _____ Triglycerides? _____

(Please bring copies of any lab reports to your next visit.)

Comments:

Atherosclerosis

ANGINA (circle the appropriate answers or fill in the blanks)

Have you ever had any pain or discomfort in your chest? **YES** **NO** (if "NO," go to HEART section)

If YES:

Do you get it when you walk uphill or hurry? **YES** **NO** **NEVER HURRY**

Do you get it when you walk at an ordinary pace on the level? **YES** **NO**

What do you do if you get it while walking? **STOP** **GO ON**

If you stand still, what happens to it? **RELIEVED** **NOT RELIEVED**

How soon? **1 - 10 min** **>10 min**

Where does it hurt? _____

Did you feel it anywhere else? _____

Have you been hospitalized because of this pain? **YES** **NO**

How long have you been having this pain? _____

Do you ever use nitroglycerin to relieve the pain? **YES** **NO**

Has your discomfort gotten worse in the last 2 months? **YES** **NO**

Comments:

HEART ATTACK

Have you ever had a severe pain across the front of your chest lasting for a half hour or more?

YES **NO** (if "NO," go to next page)

If YES:

Have you ever had a heart attack for which you were hospitalized for more than 4 days?

YES **NO** (if "NO," go to next section)

How many heart attacks have you had? _____

How old were you when you had your first heart attack? _____

Comments:

CLAUDICATION

Do you get pain in your legs or hips when walking? **YES** **NO** (if "NO," go to STROKE section)

If YES:

Does this pain ever begin when you are standing still? **YES** **NO**

Describe where it hurts _____

How far can you walk before having pain? _____

Does the pain ever disappear while you are walking? **YES** **NO**

What happens to the pain if you stand still? **RELIEVED** **NOT RELIEVED**

How soon? **1 - 10 min** **More than 10 min**

How long have you been having this pain? _____

Has your leg pain gotten worse in the last 2 months? **YES** **NO**

Comments:

STROKE OR TIA

Have you ever had a sudden lose of movement, feeling, or sight on one side of your body?

YES **NO** (if "NO," go to TESTS section)

If YES: What was lost? _____

How long did it last? **Less than 60 min** **1 to 24 hrs** **over 24 hrs**

When did it first occur? _____

How many times has it happened? _____

Has it affected different parts of your body? _____

Has it been more frequent in the past month? **YES** **NO**

Comments:

CARDIOVASCULAR TESTS

Have you had any heart or circulation tests such as:

Exercise or Treadmill test **YES** **NO** **Do not know**

Echocardiogram **YES** **NO** **Do not know**

Ultrasound of your neck or legs **YES** **NO** **Do not know**

Angiogram (dye injected into your artery) **YES** **NO** **Do not know**

(Please bring copies of any reports that you might have to your next clinic visit.)

VASCULAR PROCEDURES:

Have you had an "angioplasty" of any of your arteries? YES NO Do not know

If YES: How many have you had? _____

When did you have them? _____

Did they use a stent(s)? If so, how many? _____

Have you had a "bypass operation" on any of your arteries? YES NO Do not know

If YES: How many operations have you had? _____

Which arteries did they bypass? **HEART LEG NECK ABDOMEN OTHER**

COMMENTS:

OTHER SURGICAL PROCEDURES:

Have you had any other surgical operations? YES NO Do not know

If YES: What were they and when did you have them (year)?

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

COMMENTS:

MENSTRUAL HISTORY: (WOMEN ONLY)

If you have gone through menopause, how old were you? _____

How many pregnancies have you had? _____

When did you have your last menstrual period: _____

How frequent are your periods? **Every _____ days**

Are you taking birth control pills or estrogen now? **YES NO**

Are you using another form of birth control? **(Type: _____) YES NO NOT NEEDED**

Have you taken birth control pills in the past? **YES NO**

If YES: How many years did you use them? _____

Have you taken post-menopausal hormones in the past? **YES NO**

If YES: Which pill(s) did you use? _____

How many years did you use them? _____

Do you have Diabetes: **YES NO (if "NO," go to the NEUROPATHY section)**

When did you first develop diabetes? **Date:** _____

What type of glucose monitor do you use? _____

How often do you check your blood sugar? _____

What are typical blood sugar levels for you before breakfast? _____

What are typical blood sugar levels for you the rest of the day? _____

What diabetes medicines have you taken in the past? _____

_____ _____ _____

_____ _____ _____

NEUROPATHY: **Do you have any of the following problems?** (Onset = Date that it started)

Peripheral -

Numbness or abnormal sensations and if so, where?	**NO**	**FEET**	**HANDS**	Onset: _____
Burning, aching, stabbing and if so, where?	**NO**	**FEET**	**HANDS**	Onset: _____
Weakness and if so, where?	**NO**	**FEET**	**HANDS**	Onset: _____
Skin ulcers or sores and if so, where?	**NO**	**FEET**	**HANDS**	Onset: _____

Comments:

Autonomic –

Weakness or Fainting on standing, relieved by lying down?	**YES**	**NO**	Onset: _____
Nausea or vomiting more than 6 times each month?	**YES**	**NO**	Onset: _____
Diarrhea at night or more than 20 bowel movements/day?	**YES**	**NO**	Onset: _____
Less than 2 bowel movements/week?	**YES**	**NO**	Onset: _____
Impotence (unable to have an erection)?	**YES**	**NO**	Onset: _____
Unable to empty your bladder?	**YES**	**NO**	Onset: _____
Unable to feel a low blood sugar?	**YES**	**NO**	Onset: _____

Comments:

RETINOPATHY:

Have you been told that your eyes have been damaged by your diabetes? **YES NO** When? _____

Have you had laser treatments? **YES NO** When? _____

Have you had any other eye surgery? **YES NO**

TYPES: _____ When? _____

_____ When? _____

How is your eye-sight now? _____

Comments:

NEPHROPATHY:

Do you spill protein or albumin in your urine? **YES NO** For how long? _____

Have you been treated with dialysis? **YES NO** For how long? _____

TYPE OF DIALYSIS: **HEMO CAPD**

Have you had an organ transplant? **YES NO**

TYPE OF TRANSPLANT:	KIDNEY	PANCREAS	LIVER	HEART
When?	_____	_____	_____	_____

Comments:

OTHER MEDICAL PROBLEMS (PMH):

Do you or have you had any of the following conditions?

High blood pressure: **YES** **NO** If yes, how long have you had it? _____ years

Thyroid Disease: **YES** **NO** If yes, how long have you had it? _____ years

What type of thyroid disease is it? _____

Stomach Ulcers **YES** **NO** If yes, when did you 1st get them? _____ year

Gall Stones: **YES** **NO** If yes, when were they 1st discovered? _____ year

Were they removed? **YES** **NO** If yes, when was your surgery? _____ year

Pancreatitis: **YES** **NO** If yes, how many times have you had it? _____

When did these bouts happen? Dates: _____

Gout (uric acid): **YES** **NO** If yes, how long have you had it? _____ years

Liver Disease: **YES** **NO** If yes, how long have you had it? _____ years

What type of liver disease is it? _____

Kidney Disease: **YES** **NO** If yes, how long have you had it? _____ years

What type of kidney disease is it? _____

Have you had a head injury? **YES** **NO** If yes, when did it (they) occur? _____ year

What type of head injury was it? _____

Have you had bone fractures? **YES** **NO** If yes, when did it (they) occur? _____ year

Which bones were broken? _____

Have you ever had a bone density test (DEXA) done? **YES** **NO**

If yes, when and where were they done? _____

(Please obtain a copy of the report if possible and bring it to your next clinic visit.)

Are you allergic to anything? **YES** **NO** What? _____

_____

_____

_____

Have you ever taken steroids of any kind? **YES** **NO** What were they and for how long?

_____

_____

_____

Have you ever taken illicit drugs of any kind? **YES** **NO** What were they and for how long?

_____

_____

Current Symptoms (ROS):			**If yes, explain:**
Constitutional:			
Have you had a change in your appetite?	**YES**	**NO**	_____
Have you had any weakness?	**YES**	**NO**	_____
Have you had a change in weight?	**YES**	**NO**	_____
Cardiovascular:			
Are you having any new chest pain?	**YES**	**NO**	_____
Are you getting short of breath when you lie down?	**YES**	**NO**	_____
Vascular:			
Are your feet or legs swollen?	**YES**	**NO**	_____
Do you have any open sores on your feet or legs?	**YES**	**NO**	_____
GI:			
Do you have bloating of your stomach?	**YES**	**NO**	_____
Are you constipated?	**YES**	**NO**	_____
Are you having diarrhea?	**YES**	**NO**	_____
Are you having nausea or stomach pain?	**YES**	**NO**	_____
Are you having heartburn or reflux?	**YES**	**NO**	_____
GU:			
Have you had a change in urination?	**YES**	**NO**	_____
Do you have pain when you urinate?	**YES**	**NO**	_____
Do you have blood in your urine?	**YES**	**NO**	_____
Neurological:			
Have you been getting dizzy?	**YES**	**NO**	_____
Have you had weakness in an arm or leg?	**YES**	**NO**	_____
Have you had a change in sensation in your arms or legs?	**YES**	**NO**	_____
Skin:			
Are you having acne?	**YES**	**NO**	_____
Have you had a skin infection?	**YES**	**NO**	_____
Have you had a change in your hair?	**YES**	**NO**	_____
Do you have a rash?	**YES**	**NO**	_____
Muscular-Skeletal:			
Have you had any new joint or back pains?	**YES**	**NO**	_____
Have you had any new muscle pains or cramps?	**YES**	**NO**	_____
Hematological:			
Have you been bleeding easily?	**YES**	**NO**	_____
Have you been bruising easily?	**YES**	**NO**	_____

Life Style:

DIET

Are you currently following a special diet? **YES** **NO**

If "yes," what diet are you on? _____

How long have you been following this diet? _____

What is the most that you have ever weighed? (exclude pregnancy) _____

What is a "typical" weight for you? _____

Has your weight changed more than 5 pounds in the last year? YES NO How much? _____

How many dairy servings do you eat per day? (milk, yogurt, cheese, ice cream, etc) _____

What is a typical breakfast for you? _____

What is a typical lunch for you? _____

What is a typical supper for you? _____

What is a typical snack for you? _____

EXERCISE

Do you exercise regularly? **YES** **NO** (if "NO," go to the SMOKING section)

If "**yes,**" how often do you exercise? **daily** **2-3 days/week** **weekly**

Type(s) of exercise: _____

Duration of exercise: _____

SMOKING

Have you ever smoked cigarettes? **YES** **NO** (if "NO," go to the ALCOHOL section)

If "yes," what year did you start? _____

On average, how many packs/day have you smoked? _____

Do you currently smoke? **YES** **NO** If "no," what month and year did you quit? _____/_____

ALCOHOL INGESTION

Are you currently ingesting alcoholic beverages more than once a month? **YES** **NO**

If "yes," circle appropriate beverage, approximate frequency, and usual daily amount each session:

BEER:	frequency -	**DAILY**	**2-3 DAYS/WEEK**	**WEEKLY**
	12 oz cans each session:	**1-2**	**3-6**	**over 6**
WINE:	frequency -	**DAILY**	**2-3 DAYS/WEEK**	**WEEKLY**
	6 oz glasses each session:	**1-2**	**3-6**	**over 6**
LIQUOR:	frequency -	**DAILY**	**2-3 DAYS/WEEK**	**WEEKLY**
	1 oz shots each session:	**1-2**	**3-6**	**over 6**

What medications, vitamins, and supplements do you currently take?

(If you have a list of these items, then you do not have to complete this page.)

Name:	Dosage:	When do you take it?

Do you have any major illnesses or conditions that have not been discussed? **YES** **NO**

What are they? _____

_____

_____