Diabetes and Endocrinology
CLINICAL CONSULTANTS OF TEXAS

MEDICAL HISTORY FORM

This form is confidential and will become part of your medical record

Clinic Location:

❑ **DECCT DALLAS** 12606 Greenville Ave., Suite 200, Dallas, TX 75243

❑ **DECCT ROCKWALL** 890 Rockwall Parkway, Suite 102, Rockwall, TX 75032

Name: _____ Date: _____

Address: _____ Date of Birth: _____

Referring Provider/Primary Care Provider: _____

PLEASE DESCRIBE THE REASON FOR THE VISIT:

_____

_____

_____

_____

_____

_____

_____

PAST SURGERIES:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL MEDICAL HISTORY:

Do you have, or have you had, any of the following? Please check all which apply and write approximate dates of procedures or diagnosis:

DIAGNOSIS	DATE (Month/Year)
❑ Diabetes	_____
❑ High Blood Pressure	_____
❑ High Cholesterol ❑ Triglycerides	_____
❑ Heart Attack / Coronary Bypass / Stent	_____
❑ Heart Failure	_____
❑ Strokes / Mini-Strokes	_____
❑ Overactive Thyroid	_____
❑ Underactive Thyroid	_____
❑ Thyroid Nodules / Tumors	_____
❑ Thyroid Cancer	_____
❑ Osteoporosis	_____
❑ High / Low Calcium	_____
❑ Bariatric (obesity) Surgery	_____
❑ Sexual Hormone Deficiencies	_____
❑ other Medical Problems:	_____
_____	_____
_____	_____
_____	_____
_____	_____

PHARMACY INFORMATION:

Pharmacy Name: _____

Address: _____

Pharmacy Phone #: _____

ALLERGIES:

Are you allergic to any medications, supplements or foods? Please list below:

_____ _____

_____ _____

_____ _____

_____ _____

PERSONAL HABITS:

Do you currently use tobacco? ❑ Yes ❑ No

If yes, how much and how often? _____

Are you an Ex-Smoker? ❑ Yes ❑ No

How long ago did you quit? _____

Do you use alcohol? ❑ Yes ❑ No

If so, how much per week? _____

Do you use recreational drugs? ❑ Yes ❑ No

If so, how much per week? _____

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FAMILY HISTORY:

Do any First-Degree relatives suffer, or have previously suffered, from the following condition(s)?

CONDITION	FAMILY MEMBER
❑ Diabetes	_____
❑ Heart Attacks	_____
❑ Heart Failure	_____
❑ Strokes	_____
❑ High Cholesterol	_____
❑ Cancer	_____
❑ Amputations	_____
❑ Renal Failure	_____
❑ Blindness	_____
❑ Thyroid Disease	_____
❑ Thyroid Surgery	_____
❑ Other Serious Diseases or Conditions:	_____
_____	_____
_____	_____
_____	_____
_____	_____

FOR ALL PATIENTS:
Do you have any of the following condition(s)?

- ❑ Cough Lasting Over 7 Days
- ❑ Fever
- ❑ Night Sweats
- ❑ Positive Skin TB Test
- ❑ Abnormal Chest X-Ray
- ❑ History of Tubercolis
- ❑ Exposure to Somebody with Tubercolis

DIABETIC PATIENTS:

Do you check your blood sugar at home? _____

If Yes, how often? _____

(Please have your results or your meter available)

When was your last DIABETIC EYE EXAM? _____

Name of Eye Doctor: _____

Are you following a DIET or NUTRITIONAL Plan? _____

If Yes, please describe:

_____

Have you ever received DIABETES EDUCATION or CLASSES? If yes, when and where?

_____ / _____

Have you ever participated in a RESEARCH STUDY on Diabetes? _____

Would you be interested in learning more about RESEARCH STUDIES in Diabetes? _____

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

- ❑ Excessive Thirst
- ❑ Excessive Urination
- ❑ Nocturnal Urination
- ❑ Low Blood Sugars
- ❑ Kidney Problems
- ❑ Dry Mouth
- ❑ Frequent Infections
- ❑ Foot Infections
- ❑ Foot Ulcers or Wounds
- ❑ Sexual Dysfunction
- ❑ Dizziness Upon Standing
- ❑ Chest Pain
- ❑ Shortness of Breath
- ❑ Swelling on Your Legs
- ❑ Numbness or Tingling, where? _____
- ❑ Burning Pain, where? _____
- ❑ Recent Weight Gain, how much? _____
- ❑ Recent Weight Loss, how much? _____
- ❑ Vision Problems
- ❑ Poor Balance
- ❑ Falls
- ❑ Nausea / Vomiting
- ❑ Dental or Gum Problems
- ❑ Other Problems: _____

FOR WOMEN OF CHILD-BEARING AGE:

Are you pregnant or may you be pregnant? _____

Last Menstrual Period: _____ / _____ / _____

Do you have Tubal Ligation? _____ Hysterectomy? _____

Please ask the receptionist if you need an additional sheet of paper.

" I attest that the information provided is true and complete to the best of my knowledge. I understand that INTENTIONALLY PROVIDING FALSE OR MISLEADING INFORMATION may result in the TERMINATION of the patient-provider relationship."

Signature of Patient or Legal Guardian:

_____ Date: _____

Name (PRINT) *:*

_____

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MEDICATIONS AND SUPPLEMENTS LIST (include INSULIN)

Please bring all your medications or an updated list to every visit. FOR YOUR SAFETY, let the nurse or the physician know of ANY changes in your medications or ANY NEW medications. Some medications can cause serious adverse effects when mixed with other medications or supplements. *In order to avoid dangerous interactions, we need to know* ***EVERYTHING*** *you are taking.*

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

Medication name and form (tablet, vial, capsule, pen, etc.)	**Strength if known**	**How often?**	**How do you take it?** i.e. by mouth, injection, etc.	**Prescriber**

You can download a new Medication List at any time from our website: diabetesendotx.com