innovative
DIABETIC SOLUTIONS

# Primary Care Clinics
# Patient Questionnaire -- Adult

| **Last Name:** | **First Name:** | **DOB:** | ☐**F** ☐**M** |
|---|---|---|---|
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | | **Occupation:** | |
| **Previous or referring doctor:** | | **Date of last physical exam:** | |

## PERSONAL HEALTH HISTORY

| **Immunizations** (Include approximate year or age) | | | |
|---|---|---|---|
| | ☐ Tetanus | ☐ Pneumonia/Pneumovax | ☐ Hepatitis A |
| | ☐ Influenza (Flu) | ☐ Prevnar 13 | ☐ Hepatitis B |
| | ☐ Gardasil (HPV) | ☐ Shingles vaccine/Zostavax | |

| **Past or Present Medical History: (check all that apply to you)** | | | |
|---|---|---|---|
| ☐ Alcohol/ Drug problem | ☐ Emphysema/COPD | ☐ Liver Disease | ☐ Blood Clots |
| ☐ Anemia | ☐ Heart – Attack | ☐ Osteoporosis | ☐ Peripheral Artery Disease |
| ☐ Anxiety | ☐ Heart–Coronary Artery Dis. | ☐ Prostate problem | ☐ Neuropathy |
| ☐ Arthritis | ☐ Heart- Heart Failure/ CHF | ☐ Psychiatric- Depression | ☐ Sleep Apnea |
| ☐ Asthma | ☐ High Blood Pressure | ☐ Psychiatric Disorder--other | ☐ Heart Murmur |
| ☐ Atrial Fibrillation | ☐ High Cholesterol | ☐ Seizure Disorder | ☐ Migraines |
| ☐ Dementia | ☐ Hypothyroidism (low) | ☐ Stroke | ☐ Hepatitis |
| ☐ Diabetes | ☐ Hyperthyroidism (high) | ☐ Ulcers of the Stomach | ☐ Diverticulosis |
| ☐ Cancer— | ☐ Kidney Disease | ☐ STD/ sexual infection | ☐ Colon Polyps |
| Type: | | ☐ Abnormal Pap Test | ☐ Positive TB test |

| **Surgeries (Include Year or Age at time of surgery)** | | |
|---|---|---|
| ☐ Appendectomy | ☐ Tonsillectomy | ☐ C-Section (Cesarean) |
| ☐ Cardiac Bypass (CABG) | ☐ Hernia Repair | ☐ Hysterectomy- Partial |
| ☐ Cardiac Angioplasty/Stent | ☐ Prostate Surgery | ☐ Hysterectomy- Total |
| ☐ Gallbladder Laparoscopic | ☐ Vasectomy | ☐ Tubal Ligation |
| ☐ Gallbladder Open | ☐ Cataract Surgery: ☐ Left ☐ Right | ☐ Breast Surgery: ☐ Left ☐ Right |
| ☐ Orthopedic (type): | | |
| ☐ Other Surgery: | | |

| **Screening Tests** | Approx Date: | | | Approx Date: | | |
|---|---|---|---|---|---|---|
| Cholesterol Test | | ☐ Normal | ☐ Abnormal | Pap Smear | | ☐ Normal ☐ Abnormal |
| Colonoscopy | | ☐ Normal | ☐ Abnormal | Mammogram | | ☐ Normal ☐ Abnormal |
| Prostate Test | | ☐ Normal | ☐ Abnormal | Bone Density Test | | ☐ Normal ☐ Abnormal |
| Dental Exam | | ☐ Normal | ☐ Abnormal | | | |
| Eye Exam | | ☐ Normal | ☐ Abnormal | ☐ Glasses ☐ Contacts ☐ Cataracts | | |

innovative DIABETIC SOLUTIONS

# Primary Care Clinics
# Patient Questionnaire -- Adult

Last Name: First Name: DOB:

| **MEDICATIONS: List prescribed and over-the-counter medications.** | | |
|---|---|---|
| DRUG NAME: | DOSE & DIRECTIONS: | REASON: |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **ALLERGIES/ REACTIONS to Medications:** | |
|---|---|
| DRUG NAME: | REACTION/ COMMENTS: |
| | |
| | |
| | |
| | |
| **LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:** | |
| | |

| **SEXUAL HEALTH** | | | |
|---|---|---|---|
| ☐ Sexually active | ☐ Not currently sexually active | ☐ Never sexually active | # partners in past year: |
| History of Sexually Transmitted Infection ? ☐ No ☐ Yes Type/date: | | | |
| Current contraception method: | | Previous methods: | |
| # children: | **For Women:** (# pregnancies: ) (# miscarriages: ) (# abortions: ) | | |

| **HEALTH HABITS AND PERSONAL SAFETY** | |
|---|---|
| **Exercise** | ☐ Sedentary (No exercise) |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, 1 - 3x/week for 30 min.) |
| | ☐ Regular vigorous exercise (i.e., work or recreation >3x/week for 30 minutes) |

| **Tobacco** | **Cigarette use:** | ☐ Never | ☐ Former smoker. Quit date or age: | |
|---|---|---|---|---|
| | | ☐ Current smoker---- | # packs/day: | # years: |
| | Other tobacco use: | ☐ Pipe | ☐ Cigars | ☐ Chewing tobacco |

innovative
DIABETIC SOLUTIONS

# Primary Care Clinics
# Patient Questionnaire -- Adult

Last Name: First Name: DOB:

| | | |
|---|---|---|
| **Alcohol** | Do you drink alcohol? ☐ No ☐ Yes : ☐ 0-1 time/month ☐ 2-4 times/month ☐ every week | |
| | Each week, how many: Servings of beer? Glasses of wine? Shots/mixed drinks? | |
| | When did you last have more than 4 drinks in one day? _____ | |
| | Do you feel you should cut down on drinking? | ☐ Yes ☐ No |
| | Do people annoy you by nagging about your drinking? | ☐ Yes ☐ No |
| | Have you ever felt guilty about drinking? | ☐ Yes ☐ No |
| | Have you ever had a morning drink to steady your nerves? | ☐ Yes ☐ No |

| | | |
|---|---|---|
| **Drugs** | Have you used recreational or street drugs within the last 2 years? | ☐ Yes ☐ No |
| | Have you ever used recreational drugs with a needle? | ☐ Yes ☐ No |

| | | |
|---|---|---|
| **Personal Safety** | Do you wear seatbelts? | ☐ Yes ☐ No |
| | Do you have frequent falls? | ☐ Yes ☐ No |
| | Does your house have a working smoke detector? | ☐ Yes ☐ No |
| | Do you experience conflicts in your relationships that take the form of verbally threatening behavior, mental abuse, physical abuse or sexual abuse? | ☐ Yes ☐ No |

**FAMILY HEALTH HISTORY**

| Family Member | | | Age | MEDICAL CONDITIONS (Indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer &type) |
|---|---|---|---|---|
| **Mother** | | ☐ Living ☐ Deceased | | |
| **Father** | | ☐ Living ☐ Deceased | | |
| **Grandmother** *Mother's Side* | | ☐ Living ☐ Deceased | | |
| **Grandfather** *Mother's Side* | | ☐ Living ☐ Deceased | | |
| **Grandmother** *Father's Side* | | ☐ Living ☐ Deceased | | |
| **Grandfather** *Father's Side* | | ☐ Living ☐ Deceased | | |
| **Sibling** | ☐ M ☐ F | ☐ Living ☐ Deceased | | |
| **Sibling** | ☐ M ☐ F | ☐ Living ☐ Deceased | | |
| **Sibling** | ☐ M ☐ F | ☐ Living ☐ Deceased | | |
| **Sibling** | ☐ M ☐ F | ☐ Living ☐ Deceased | | |
| **Sibling** | ☐ M ☐ F | ☐ Living ☐ Deceased | | |
| | | ☐ Living ☐ Deceased | | |
| | | ☐ Living ☐ Deceased | | |

*Reviewed by/ Date:*

innovative
DIABETIC SOLUTIONS

# System Review for Adults---
# New Patient or Annual Preventive Visit

**Name:** **Today's Date:**

**Date of Birth:**

## Check the box if you are currently experiencing any of the following:

**GENERAL:**
- ☐ Fatigue
- ☐ Fever
- ☐ Weight gain > 10 lbs
- ☐ Weight loss > 10 lbs

**SKIN:**
- ☐ Rash
- ☐ New/changing skin lesion
- ☐ Nail changes
- ☐ Hair loss

**EYES/EARS/NOSE/THROAT:**
- ☐ Vision changes
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Lump in neck

**RESPIRATORY:**
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Night sweats
- ☐ Bloody sputum
- ☐ Productive cough
- ☐ Dry cough
- ☐ Shortness of breath

**CARDIOVASCULAR:**
- ☐ Chest pain
- ☐ Racing heart
- ☐ Irregular heartbeat
- ☐ Shortness of breath
- ☐ Leg pain with walking
- ☐ Ankle or Leg swelling
- ☐ Decreased exercise tolerance
- ☐ Awakening at night due to trouble breathing

**GASTROINTESTINAL:**
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Rectal bleeding

**MUSCULOSKELETAL:**
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Muscle weakness

**HEMATOLOGIC:**
- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Enlarged lymph nodes

**NEUROLOGIC:**
- ☐ Headaches
- ☐ Dizziness/vertigo
- ☐ Numbness/tingling
- ☐ Passing out
- ☐ Difficulty walking
- ☐ Seizures
- ☐ Tremor
- ☐ Frequent falls

**PSYCHIATRIC:**
- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Suicidal thoughts
- ☐ Insomnia/sleep problems
- ☐ Psychiatric treatment

**ENDOCRINE:**
- ☐ Change in appetite
- ☐ Cold or heat intolerance
- ☐ Increased thirst
- ☐ Changes in sex drive
- ☐ Hair loss or excess growth

**ALLERGIC/IMMUNOLOGIC:**
- ☐ Allergy/Hayfever symptoms
- ☐ Itching
- ☐ Frequent infections
- ☐ Exposure to infection

**BREAST:**
- ☐ Breast lump/mass
- ☐ Breast pain
- ☐ Nipple discharge
- ☐ Rash on breast

**GENITOURINARY:**
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Loss of bladder control
- ☐ Difficulty passing urine
- ☐ Hernia

MEN:
- ☐ Difficulty starting stream
- ☐ Change in urine stream
- ☐ Penile discharge
- ☐ Testicular pain or mass
- ☐ Erection difficulties

WOMEN:
- ☐ Pelvic pain
- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Excessive vaginal bleeding
- ☐ Bleeding after menopause
- ☐ Vaginal dryness
- ☐ Hot flashes
- ☐ Pain with intercourse

*Reviewed by/Date:*