

INITIAL MEDICAL HISTORY
IDAHO DIABETES AND ENDOCRINE ASSOCIATES, P.A.

NAME: _____ BIRTHDATE: _____ TODAY'S DATE: _____

AGE: _____ HEIGHT: _____ FT. _____ IN. WEIGHT: _____ LBS.

Have you ever had:	No	Yes	Recently	Do you now have or have you ever had:	No	Yes	Recently
Rheumatic Fever				Any eye disease, injury, impaired sight			
Heart Disease				Any ear disease, injury, impaired hearing			
Heart Murmur				Any trouble with nose, sinuses, mouth/throat			
Shortness of Breath				Any head injury, fainting spells or convulsions			
Swelling of hands, feet, or ankles				Frequent or severe headaches			
Pneumonia				Thyroid Disease			
Kidney infections				Skin Disease			
Sexually transmitted diseases (STDs)				Chronic or frequent cough			
Bladder infection				Chest pain, or spitting up blood			
Anemia				Night Sweats (soaking)			
Jaundice				Varicose Veins			
Gallbladder Disease				Kidney Disease			
Breast Disease				Indigestion, stomach trouble or ulcer			
Blood Clots				Rectal bleeding, severe constipation, diarrhea			
Fractures or Injuries				Loss of urine with cough, sneeze or strain			
Liver Disease or Hepatitis				Abnormal vaginal bleeding			
Diabetes				Abnormal Pap Smears			
Take Insulin for Diabetes				Hysterectomy			
Epilepsy				Ovaries removed			
Anxiety							
Depression							
Migraine Headaches							
Cancer							
High Blood Pressure							
Autoimmune Disorders							

Surgical History: What, When, Where? _____

Allergies: _____

Current Medications including vitamins and supplements: _____

Habits:	Never	Moderately	Daily
Alcoholic Beverages	_____	_____	_____
Exercise	_____	_____	_____
Cigarettes	_____ packs per day	_____ years	

INITIAL MEDICAL HISTORY CON'T.

FAMILY HISTORY

	LIVING		IF DECEASED		Has any relative had	NO	YES	WHO
	AGE	Health	AGE	Cause				
Father								
Mother								
Brother/Sister								
Husband								
Son or Daughter								

Should the doctor or nurse discuss the following?

Difficulties with sex _____
 Abuse _____
 Sexually transmitted diseases _____

Menopausal symptoms _____
 Lifestyle changes _____

For Women Only:

OB History:

List of Pregnancies including miscarriages					
Year	Child's Weight	Sex	Hours of Labor	Anesthesia	Complications

Menstrual History:

Age at Beginning _____
 Regular _____ Yes _____ No _____
 How Many days is your cycle: _____
 Is your flow _____ Light _____ Moderate _____ Heavy _____
 Pains or cramps _____ Yes _____ No _____
 Date of last period? ____/____/_____
 Date of last PAP Smear? ____/____/_____