Diabetes/Lipid Metabolism Clinic

History Questionnaire

Name: ______________________ Date of Birth: ______________

Date: ___________ Race: ______________

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

AGE: ________ FAX#: ____________ E-mail: __________________

SOCIAL SECURITY # ________________ MED. REC. #: ______________

ADDRESS: ______________________ PHONE (home): ______________

______________________ (work): ______________

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 like discussed 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? ________ Triglyceride? ________

How long have they been elevated? ______________________

What medications have you taken for this condition? ______________________

____

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

What type of reaction(s) did you have? ______________________

____

____

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

Within the last two months,

has your chest discomfort occurred more often?	YES	NO
has the pain become more severe?	YES	NO
has the pain lasted longer when it occurs?	YES	NO
have you started getting the pain when sitting still?	YES	NO
have you started getting the pain when sleeping?	YES	NO

Comments:

HEART ATTACK

Have you ever had a severe pain across the front of your chest lasting for half an 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 or sitting? YES NO

Describe where it hurts? ______________________________

Do you get this pain if you walk uphill or hurry? YES NO NEVER HURRY

Do you get it if you walk at an ordinary pace on level ground? YES NO

How far can you walk before having pain? ______________________________

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

What do you do if you get this pain while walking? STOP SLOW CONTINUE

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

How soon? 1 - 10 min More than 10 min

Have you been hospitalized because of this pain? YES NO

How long have you been having this pain? ______________________________

Within the last two months,

has your leg pain occurred more often? YES NO

has the pain become more severe? YES NO

has the pain lasted longer when it occurs? YES NO

have you started getting the pain with less exertion? YES NO

have you started getting the pain when sitting still? YES NO

have you started getting the pain when sleeping? 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 next page)

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? ______________________________

Who many times has it happened? ______________________________

Has it affected different parts of your body? ______________________________

Has it been occurring more frequently in the past month? YES NO

Comments:

CARDIOVASCULAR STUDIES: **(Please bring copies of any reports to your next visit.)**

Have you had an "exercise" or "treadmill" test? **YES NO Do not know**

If YES: How many have you had? ____________

When did you have them? ____________

Where did you have them? ____________

Were any of them abnormal? ____________

What was the abnormality? ____________

Have you had an "echocardiogram"? **YES NO Do not know**

If YES: How many have you had? ____________

When did you have them? ____________

Where did you have them? ____________

Were any of them abnormal? ____________

What was the abnormality? ____________

Have you had an "ultrasound" of your neck arteries? **YES NO Do not know**

If YES: How many have you had? ____________

When did you have them? ____________

Where did you have them? ____________

Were any of them abnormal? ____________

What was the abnormality? ____________

Have you had an "ultrasound" of your leg arteries? **YES NO Do not know**

If YES: How many have you had? ____________

When did you have them? ____________

Where did you have them? ____________

Were any of them abnormal? ____________

What was the abnormality? ____________

Have you had an "ultrasound" or "dopplers" of your leg veins? **YES NO Do not know**

If YES: How many have you had? ____________

When did you have them? ____________

Where did you have them? ____________

Were any of them abnormal? ____________

What was the abnormality? ____________

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

If YES: How many have you had? ____________

When did you have them? ____________

Where did you have them? ____________

Were any of them abnormal? ____________

VASCULAR PROCEDURES:

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

If YES: How many have you had? ______________

When did you have them? ______________

Where did you have them? ______________

Which artery did they treat? HEART LEG NECK ABDOMIN OTHER

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? ______________

When did you have them? ______________

Where did you have them? ______________

Which arteries did they bypass? HEART LEG NECK ABDOMIN OTHER

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) ______________

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:

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

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? ____

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

What type of thyroid 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?

____

____

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

What are they? ____

____

____

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 below:

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

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?

PHYSICAL EXAM (1) Name: ______________________ Date: ______________________

General Appearance:* ____

Skin:*

Xanthomas	No	Yes
Xanthelasmas	No	Yes
Tendon xanthomas	No	Yes

Eyes:*

Conjunctivae	Normal	Jaundice			
Cataracts	No	Yes	Right	Left	
Hemorrhages	No	Yes	Dot	Flame	Vitr.
Exudates	No	Yes	Soft	Hard	
A-V Nicking	No	Yes			
Neovascularization	No	Yes			

Ears:*

Canals	Clear	Excessive Cerumen	Infected/Inflamed
TMs	Normal	+Fluid	Infected/Inflamed

Neck:*

Thyroid	Palp/Normal	Non-palp	Abnormal: ____________
Neck	Supple		Abnormal: ____________

Lungs:*

Rales	No	Yes
Rhonchi	No	Yes
Wheezes	No	Yes
Breath Sounds	Normal	Reduced
Respir. Effort	Normal	Increased

Blood Pressure:*		**Pulse:**
Supine -	____________	_____
Sitting -	____________	_____
Standing -	____________	_____

Breasts:

Mass	No	Yes
Discharge	No	Yes

Temp: _________

Respir: _________

Weight: _________

Height: _________

Cardiovascular System:*

Edema	No	Yes
JVD	No	Yes
Enlarged heart	No	Yes
Murmur	No	Yes
S3	No	Yes
S4	No	Yes

Pulses:

Right				Left			
Carotid	0	1	2	Carotid	0	1	2
Radial	0	1	2	Radial	0	1	2
Femoral	0	1	2	Femoral	0	1	2
Dorsalis Pedis	0	1	2	Dorsalis Pedis	0	1	2
Posterior Tibial	0	1	2	Posterior Tibial	0	1	2

Bruits:

Carotid	No	Yes	Right	Left
Subclavian	No	Yes	Right	Left
Abdominal	No	Yes	Right	Left
Femoral	No	Yes	Right	Left

PHYSICAL EXAM (2) **Name:** ______________________________ **Date:** ______________________

Abdomen:*

Hepato/splenomegaly	No	Yes
Aneurysm	No	Yes
Mass	No	Yes
Tenderness	No	Yes

Rectal:

Mass	No	Yes
Blood	No	Yes
Prostate	______________________	

Neuropathy:*

Sensory	No	Yes	Pinprick: ______________________
(Describe findings precisely, even if normal)			Position: ______________________
			Vibration: ______________________
			Monofilament: ______________________
Abnormal DTR	No	Yes	Knees R ______ L ______ Ankles R ______ L ______ Others:
(Weakness)	No	Yes	Generalized Right Left
(Gait)	Normal	Abnormal	______________________

Lymph Nodes:

Neck	Normal	Abnormal	______________________
Axilla	Normal	Abnormal	______________________
Groin	Normal	Abnormal	______________________
Other ____________	Normal	Abnormal	______________________

Pelvic:

Ext. Genitalia, Vagina	Normal	Abnormal	______________________
Cervix	Normal	Abnormal	______________________
Uterus	Normal	Abnormal	______________________
Adnexa	Normal	Abnormal	______________________

Male GU:

Scrotal Contents	Normal	Abnormal	______________________
Penis	Normal	Abnormal	______________________

Billing:

	New Patient	**Return Patient**
Level 1	1 Element	None
Level 2	6 Elements, ≥1 Systems	1 Element
Level 3	12 Elements, ≥2 Systems	6 Elements, ≥1 Systems
Level 4	2 Elements x 9 Systems*	12 Elements, ≥2 Systems
Level 5	2 Elements x 9 Systems*	2 Elements x 9 Systems*

*Complete all elements in sections marked with * except (---)
Pulse, BP, supine BP, temperature, respirations, weight, and height are separate (7) elements

Medications:

Diabetic: ______________________
____
____
____

Lipid: ______________________
____
____
____

Hypertensive: ______________________
____
____
____
____
____

Hormones: ______________________
____
____

Anticoagulant: ______________________
____
____

Vitamins: ______________________
____
____
____

Others: ______________________
____
____
____

Medication Reactions: ____
____

Problem List:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________
6) ______________________
7) ______________________
8) ______________________
9) ______________________
10) ______________________

Plan:

1) Pending lab: ____
2) Scheduled studies or procedures: ______________________________________
3) Physician Referrals: ____
4) Medication changes: ______________________ ______________________
______________________ ______________________
______________________ ______________________
5) Life-style changes: ____
6) RTC ____________ with lab: **here** or **at home** (when?) ______________________

Lab to be done: ____