Diabetes Associates
Medical Group, Inc.

Name_____

DOB _____

DATA BASE PAST AND FAMILY HISTORIES

PLEASE CHECK (X) ON THE LEFT WHICH OF THE FOLLOWING DISEASES/CONDITIONS YOU HAVE HAD:

____Measles _____	____Valley Fever _____	____Infectious Mononucleosis _____
____Mumps _____	____Diabetes _____	____Malaria _____
____Chicken Pox _____	____Pancreatitis _____	____Heart Trouble _____
____Whooping Cough _____	____Hypoglycemia _____	____Phlebitis _____
____Scarlet Fever _____	____Thyroid Disease _____	____Kidney Trouble _____
____Rheumatic Fever _____	____Gout _____	____Protein in Urine _____
____Pneumonia _____	____High Blood Pressure _____	____Kidney Stones _____
____Pleurisy _____	____High Cholesterol _____	____Bladder Infections _____
____Emphysema _____	____Liver Disease _____	____Ulcers _____
____Tuberculosis _____	____Infectious Hepatitis _____	____Diverticulosis _____
____Arthritis _____	____Polio _____	____Bleeding Tendency _____
____Syphilis _____	____Gonorrhea _____	____Epilepsy _____

Have you ever had any form of surgery? Yes____ No____ If answer is yes, please indicate date._____

____Hernia _____	____Caesarean Section _____	____Heart Surgery _____
____Appendectomy _____	____Hemorrhoidectomy _____	____Blood Vessel Surgery _____
____Gall Bladder _____	____Prostatectomy _____	____Laser _____
____Tonsillectomy _____	____Hysterectomy _____	____ _____

Have you ever had any serious accidents? Yes_____ No_____ Fractured (Broken) Bones? Yes_____ No_____
Head Injury? Yes_____ No_____ Back Injury? Yes_____ No_____ Whiplash? Yes_____ No_____

Other than childbirth and the above listed surgeries, have you been in the hospital for any other reasons? Yes_____ No_____
For what reason? _____

_____

ALLERGIES:

Are you allergic to any type of medications? Yes_____ No_____ If so please check
Penicillin_____; Sulfa_____; Antibiotics_____; Aspirin_____; Codeine_____; Demerol_____; Novacaine_____
Other _____
Do you have now, or have you had in the past, any of the following?
Asthma_____; Hives_____; Hay Fever_____; Eczema_____;

Do you smoke? Yes_____ No_____ Packs per day_____ Age started smoking_____ Age you quit _____
Do you drink alcoholic beverages? Yes_____ No_____ _____
Have you ever been under psychiatric care? Yes_____ No_____ _____

FAMILY HISTORY:

Please check whether the following relatives are living or deceased, and their year of birth:

	Living	Dead	Yr. of Birth	Age at Death	Do Not Write		Living	Dead	Yr. of Birth	Age at Death	Do Not Write
Mat. Grandmother	___	___	_____	_____	_____	Pat. Grandmother	___	___	_____	_____	_____
Mat. Grandfather	___	___	_____	_____	_____	Pat. Grandfather	___	___	_____	_____	_____
Mother	___	___	_____	_____	_____	Father	___	___	_____	_____	_____
Sisters	_____	___	_____	_____	_____	Brothers	_____	___	_____	_____	_____
	_____	___	_____	_____	_____		_____	___	_____	_____	_____
	_____	___	_____	_____	_____		_____	___	_____	_____	_____

How many children do you have? _____
Have any of your relatives (parents, grandparents, uncles, aunts, brothers, sisters or children) had any of the following diseases?
Please check (X) which they have had on the line to left of disease. (Do not write to right of disease).

____Diabetes _____	____Coronaries _____	____Epilepsy _____
____Gout _____	____Heart Trouble _____	____Parkinson's _____
____Thyroid _____	____Kidney Trouble _____	____Arthritis _____
____High BP _____	____Kidney Stones _____	____Ulcers _____
____Strokes _____	____Cancer _____	____TB _____

Reviewed: _____