## **Diabetes and Thyroid Center of Fort Worth, PLLC**

## **HISTORY QUESTIONNAIRE**

| Name:             |   |  |            |               | DOB:         |           |                 | Today's Date: |             |  |
|-------------------|---|--|------------|---------------|--------------|-----------|-----------------|---------------|-------------|--|
| Reason for visit: |   |  |            |               |              |           |                 |               |             |  |
| 110               | 23011 101 VI3IL   |  |            |               |              |           |                 |               |             |  |
| S                 | Marital Status: [Siz  |  | /arried1   | [/\/id        | owed /       | / 1       | [Divorced /     | ' / <b>1</b>  |             |  |
|                   | _   | Marital Status: [Single] [Married] [Widowed//] [Divorced/_/] |            |               |              |           |                 |               |             |  |
| 0                 | Occupation: [Retired] [Active]  Do you: {Please circle No or Yes and explain if Yes}                          |  |            |               |              |           |                 |               |             |  |
| С                 | Get exercise [No] [Yes] ⇒ hours per week: type of exercise:   |  |            |               |              |           |                 |               |             |  |
| 1                 | Use illegal drugs [No] [Yes] ⇒  |  |            |               |              |           |                 |               |             |  |
| Α                 | Use alcohol [No] [Yes] ⇒ ounces per day   |  |            |               |              |           |                 |               |             |  |
| L                 | Use tobacco [No] [Yes] ⇒ packs per day for years current past   |  |            |               |              |           |                 |               |             |  |
| _                 |   |  |            |               |              |           |                 |               |             |  |
|                   | What medications are you currently taking (include supplements and vitamins)? Please list dose and frequency. |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
| Р                 |   |  |            |               |              |           |                 |               |             |  |
| Α                 |   |  |            |               |              |           |                 |               |             |  |
|                   | Have you had provious surgeries:  |  |            |               |              |           |                 |               |             |  |
| S                 | Have you had previous surgeries:  |  |            |               |              |           |                 |               |             |  |
| Т                 |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
| M                 | Problems for which you have seen a physician or have been treated for:  |  |            |               |              |           |                 |               |             |  |
|                   | Troblems for which  | i you nav  | c scen a p | , i i y S i   |              |           | ge if necessary | y)            |             |  |
| E                 | Diabetes  | [No]   | [Yes]      | $\Rightarrow$ | Type         | -         | Year            |               |             |  |
| D                 | Cancer  | [No]   | [Yes]      | ⇒             | Type         |           | Year            |               |             |  |
|                   | Nodule/Tumor  | [No]   | [Yes]      | ⇒             |              |           |                 |               |             |  |
| ı                 | Cholesterol   | [No]   | [Yes]      | ⇒             |              |           |                 | Side effects? |             |  |
| С                 | Stroke  | [No]   | [Yes]      | ⇒             | Year         |           |                 |               |             |  |
|                   | Blood pressure  | [No]   | [Yes]      | ,             | Year         |           |                 |               |             |  |
| Α                 | Heart problem   | [No]   | [Yes]      | ⇒             | Year         |           |                 |               |             |  |
| L                 | Eye disease   | [No]   | [Yes]      | . ⇒           | Diabetic?    |           |                 | Treatment     |             |  |
|                   | Kidney disease  | [No]   | [Yes]      | $\Rightarrow$ | Diabetic?    |           | Year            |               |             |  |
|                   | Foot infections   | [No]   | [Yes]      | $\Rightarrow$ |              |           | Year            |               |             |  |
|                   | Thyroid disease   | [No]   | [Yes]      | $\Rightarrow$ | Type         |           |                 |               |             |  |
|                   | Others  | [No]   | [Yes]      | $\Rightarrow$ |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   | Do you have any al  | lergies/re   | eactions?  | {ple          | ase list rea | ction}    |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   |   |  |            |               |              |           |                 |               |             |  |
|                   | Do any of your blood relatives have or have had any of these diseases or                                      |  |            |               |              |           |                 |               |             |  |
| _                 | Do any other proble<br>Diabetes   | ems run  |            |               | ol →         | Type:     |                 |               |             |  |
| F<br>A            | Diabetes [No] Cancer [No]   |  |            | [Ye           | •            | Type:     |                 |               |             |  |
| M                 | Tumor/lesion  |  | [No]       | [Yes]         | -1           | Location: |                 |               |             |  |
| 1                 | Heart problem   |  | [No]       | [Ye           |              |           |                 |               |             |  |
| L<br>Y            | тв  |  | [No]       | [Ye           | -            |           |                 |               |             |  |
| T                 | Thyroid disease   |  | [No]       | [Ye           | -            | Туре:     |                 |               |             |  |
|                   | High blood pressure   |  | [No]       | [Ye           | -            |           |                 |               | <del></del> |  |
|                   | Stroke  |  | [No]       | [Ye           | sj           |           |                 |               |             |  |