NORTH TEXAS DIABETES AND ENDOCRINOLOGY
4101 Kirkpatrick Ln
Flower Mound, TX 75028
214-513-2300
214-513-2333 (Fax)

MEDICAL HISTORY QUESTIONNAIRE

DATE: ____/_____/____

NAME: _____

AGE: _____ HEIGHT:_____ WT:_____

INITIAL HISTORY

1. WHY ARE YOU COMING TO THE DOCTOR? _____
_____

2. HAVE YOU EVER HAD ANY OF THE FOLLOWING (Please check)?

○ DIABETES
○ HIGH BLOOD PRESSURE
○ HIGH CHOLESTEROL
○ HEART ATTACK
○ THYROID PROBLEMS (since when:_____)
○ STROKE / MINI STROKE (Please circle)
○ ASTHMA / ALLERGIES (Please circle)
○ LUNG DISEASE
○ CANCER (which one:_____)
○ GOUT
○ DEPRESSION / ANXIETY
○ OTHERS_____

3. LIST ANY SURGERIES THAT YOU HAVE HAD:

SURGERY: _____ YEAR: _____

SURGERY: _____ YEAR: _____

SURGERY: _____ YEAR: _____

4. LIST ANY PAST HOSPITALIZATIONS:

WHEN:_____ WHY: _____

WHEN: _____ WHY:_____

5. WHAT MEDICATIONS ARE YOU TAKING (If Diabetic, see Diabetes Questionnaire)?

MEDICATION_____ DOSE_____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE _____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE _____
MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____
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MEDICATION _____ DOSE_____
MEDICATION _____ DOSE_____

6. ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, WHICH ONES? _____

_____

7. FAMILY HISTORY:
A) DO YOU HAVE FAMILY MEMBERS WITH DIABETES? YES NO

IF YES, WHO HAS DIABETES? _____

B) DO YOU HAVE FAMILY MEMBERS WITH A THYROID PROBLEM? YES NO

IF YES, WHO HAS THYROID PROBLEM?_____

C) PLEASE CHECK IF BLOOD RELATED MEMBERS OF YOUR FAMILY HAVE HAD ANY OF THE FOLLOWING:

_____ HEART DISEASE _____ KIDNEY FAILURE _____ OBESITY (who? ……..)

_____STROKE _____THYROID CANCER _____ HIGH BLOOD PRESSURE

_____ PITUITARY DISORDER _____ HIGH CHOLESTEROL _____CANCER (which one? ……..)..

8. IMMUNIZATION: WHEN

FLU SHOT	_____
PNEUMO VACC	_____

9. SOCIAL HISTORY:

MARITAL STATUS: Single Married Divorced Separated Widowed

DO YOU SMOKE CIGARETTES?_____ HOW MANY PACKS /DAY?_____

DO YOU DRINK ALCOHOL?_____HOW MANY PER DAY?_____

JOB / PROFESSION: ACTIVITY: Sedentary / Moderately active/ Very active

10. **CURRENT SYMPTOMS** (Review of Systems):

General:

Weight Gain	YES OR NO (How much? _____)
Special Dietary changes if any: _____	
Weight Loss	YES OR NO (How much? _____)
Weakness	YES OR NO
Fatigue	YES OR NO

Skin:

Hair Loss	YES OR NO
Itching	YES OR NO
Dryness	YES OR NO

Eyes, Ear, Nose & Throat:

Blurred vision (recent)	YES OR NO
Cataract	YES OR NO
Laser Treatment (not LASIK)	YES OR NO (when? _____)

Chest:

Cough	YES OR NO
Shortness of breath	YES OR NO
Snore	YES OR NO

Cardiovascular:

Chest pain	YES OR NO
Palpitations	YES OR NO
Shortness of breath with exertion	YES OR NO

Shortness of breath while lying flat	YES OR NO
Swelling of the legs/ ankles	YES OR NO
Painful legs while walking	YES OR NO
Foot ulcers	YES OR NO

Gastrointestinal:

Loss of appetite	YES OR NO
Excessive hunger	YES OR NO
Heartburn	YES OR NO
Nausea	YES OR NO
Abdominal pain	YES OR NO
Constipation	YES OR NO
Loose bowel movements (diarrhea)	YES OR NO

Urinary:

Frequent urination	YES OR NO
Problem starting stream	YES OR NO
Incontinence	YES OR NO

Genital:

Libido (desire)	Normal or Low
Men:	
Erection problems	YES OR NO
Women:	
Regular periods	YES OR NO
No. of pregnancies: _____	
Menopause	YES OR NO (age at menopause:_____)
If yes: natural or surgical	
Age, periods started: _____	
Last menstrual period: _____	

Musculoskeletal:

Arthritis	YES OR NO
If yes: what joints bother you the most: _____	
Tendonitis/ Bursitis	YES OR NO
Back or neck pain	YES OR NO

Neurological:

Frequent headaches	YES OR NO
Burning sensation or pain in the feet	YES OR NO
Numbness in the feet	YES OR NO
Pain or numbness in the hands	YES OR NO
Depressed	YES OR NO
Mood swings	YES OR NO

If you are seeing Dr. Haque for Diabetes, please fill out the Diabetes 1st visit Questionnaire as well.

_____ _____
Patient Signature Date

_____ _____
Wasim A. Haque, M.D. (Reviewed with the patient) Date