PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

Adult Medical History Form____
Please complete BOTH PAGES *NAME (both first and last)*

Your answers on this form will assist your clinician understand your medical concerns and conditions better. If you are uncomfortable with any question, please feel free not to answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

MEDICATIONS: Prescription and non-prescription medicines, vitamins, birth control pills, insulin:

Medication	Dose	Quantity	Times per day

Medication	Dose	Quantity	Times per day

ALLERGIES or REACTIONS TO MEDICATIONS:

Medication	Reaction or Side Effect

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis):

___Heart Disease: ***specify***_____________________
___Hypertension (High Blood Pressure)
___Diabetes
___High cholesterol
___PAD
___Stroke
___Osteoporosis
___Thyroid problem
specify type_________________________________

___Cancer (Malignancy)
specify type___________________________
___Depression/anxiety

Other problems

____
____
____

SURGICAL HISTORY (Please list all prior operations and dates):

Operation	Date

Operation	Date

SOCIAL AND PREVENTIVE HISTORY

Do you currently smoke or chew tobacco? ☐Yes ☐No
How many packs per day? ________________________

If no, have you in the past? ☐Yes ☐No
What year did you quit? _______________

Do you drink alcohol, beer, or wine? ☐Yes ☐No
How many drinks per week? ______________________

If no, have you in the past? ☐Yes ☐No
What year did you quit? _______________

Do you exercise? ☐Yes ☐No

If yes, number of times per week?_______

Have you been gaining weight? ☐Yes ☐No
Have you been losing weight? ☐Yes ☐No

If yes, how many pounds?______________
If yes, how many pounds?______________

FAMILY HISTORY

	Living	Age (or age at death)	List serious illnesses
Mother	☐Yes ☐No	___________________	____
Father	☐Yes ☐No	___________________	____
Sisters	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
Brothers	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
Daughters	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
Sons	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____
	☐Yes ☐No	___________________	____

Has any member of your family (including children and parents) had any of the following illnesses?

Illness	Which family member?
Cancer	____
Diabetes	____
Heart Disease	____
High Blood Pressure	____
High Cholesterol	____
Thyroid Disease	____
Stroke	____
Other serious illness	____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature ____ **Date**_____________