Arizona Integrative Medical Solutions
4657 S. Lakeshore Dr, Ste #1
Tempe, AZ 85282
480-284-8155

Diabetic Health History

Patient Name: _____ Date: _____ DOB: _____Age:_____

Street Address: _____

City: _____State: _____ Zip: _____

Home phone: _____Work Phone: _____Cell Phone: _____

Email:_____

Pharmacy Name, Address, Phone: _____

Highest level of education: _____

Occupation: _____ Employer _____Hours work per week: _____

Marital Status (circle): Single Married Partner Separated Divorced Widowed

Insurance Company: _____ Policy: _____Group #: _____

Name of Insured: _____Relation to Insured: _____

Does your insurance cover LabCorp or Sonora Quest?:_____

Person to call in case of Emergency: _____ Relationship to you: _____

Phone number for emergency contact: _____

Previous/Current Physician and City: _____

How did you hear of the clinic? _____

Please list any Additional Questions or Expectations of your visit today:

_____

Diagnosis/Labs

What type of diabetes do you have: _____

Do you have a family history of diabetes_____

When were you diagnosed with diabetes: _____

Please list out any other medical conditions you have:_____

_____

When was your last blood work: _____

On average, what is your typical A1C:_____

Are there any other labs that are problematic regularly:_____

What type of glucose meter do you use:_____

How many times a day and when during the day (fasting, after lunch, etc.) do you check your blood sugars:

Do you have any diabetic complications? (Nerve, Eyes, Kidneys, Cardiovascular disease):

_____

When was your last diabetic eye exam?_____

Do you check your feet daily?_____

List All Surgeries and Hospitalizations:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____Date: _____
5. _____Date:_____

List All Accidents, Injuries, Physical Traumas:

1._____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Please Note When and Why You Had Each of The Following:

X-rays: _____

MRI/Cat Scans: _____

Ultrasounds: _____

Please give full name, dosage, how often and how long you have taken each medicine/supplement.

Pharmaceuticals	**Dose**	**When/How Often**	**When Started**
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

If you are taking insulin please answer the following questions (If not, please skip to supplements below):

Are you using vials/syringes, pens, pump:_____

What is your typical dose of insulin, when you inject?_____

Where do you tend to inject insulin?_____

Have you had any serious hypoglycemia events:_____

Do you have lows and highs regularly with your glucose levels:_____

How do you treat hypoglycemia:_____

Do you have hypoglycemic unawareness?_____

Do you have a diabetic ID and if so, do you wear it regularly?_____

Do you have a glucagon kit? Have you ever needed to use it?_____

How do you measure ketones and when was the last time you needed to do so?_____

Supplements	**Dose**	**When/How Often**	**How Long**
1.			
2.			
3.			
4.			
5.			
6.			

Please List All Sensitivities/Allergies/Reactions

Drugs: _____

Foods: _____

Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N		Diptheria:	D I N	
Mumps:	D I N		Tetanus:	D I N	
Rubella:	D I N		Whooping Cough:	D I N	
Chickenpox:	D I N		Hemophilus (Hib):	D I N	
Hepatitis B:	D I N		German Measles:	D I N	
Polio:	D I N				

Any vaccination reactions: _____

List Yes, No, or Past regarding use of the following:

Antacids: Y N P
Steroids: Y N P
Smoking: Y N P Packs per day if Yes/Past: _____
Analgesics: Y N P
Laxatives: Y N P
Coffee: Y N P Cups per day if Yes/Past: _____
Soda Pop: Y N P Ounces per day if Yes/Past: _____
Alcohol: Y N P How often and how much if Yes/Past: _____

Any alcohol addiction: Y N P
Any alcohol treatment: Y N P
Recreational drugs: Y N P
Any drugs addiction: Y N P
Any drug treatment: Y N P

Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
Addiction	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

Any other conditions: _____

_____

Review of Systems:

Present Weight: _____ Height: _____ Max Height: _____

Maximum Weight and when: _____

Minimum Weight and when: _____

Weight one year ago: _____ Ideal Weight: _____

History of weight loss/weight regain dieting?_____

REGARDING THE NEXT SECTION: **Please Circle** Y if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

The general state of your health is: Excellent Good Average Fair Poor

On average describe your energy level from 1 (low)-10: (high) _____

If you have fatigue, when is it the worst: morning, afternoon, evening? _____

If you have fatigue, can you do what you need to during the day? Y N

Skin:

Rash/hives:	Y	N	P		Color Change:	Y	N	P
Acanthrosis Nigracans :	Y	N	P		Lump:	Y	N	P
Psoriasis/eczema:	Y	N	P		Itchy:	Y	N	P
Dry:	Y	N	P		Warts/moles:	Y	N	P
Cancer:	Y	N	P		Perspiration:	Y	N	P

Head:

Headache:	Y	N	P		Migraine:	Y	N	P
Dandruff:	Y	N	P		Head Injury:	Y	N	P
Oil/dry hair:	Y	N	P		Hair loss:	Y	N	P

Eyes:

Dry/Watery:	Y	N	P		Glaucoma:	Y	N	P
Vision changes:	Y	N	P		Cataracts:	Y	N	P
Styes:	Y	N	P		Macular Degeneration:	Y	N	P
Strain:	Y	N	P		Discharge:	Y	N	P
Itchy:	Y	N	P		Dark under eyelid:	Y	N	P

Ears:

Infections:	Y	N	P		Ear Wax:	Y	N	P
Hearing Loss:	Y	N	P		Tinnitus:	Y	N	P

Nose:

Frequent colds:	Y	N	P		Nosebleeds:	Y	N	P
Congestion:	Y	N	P		Post nasal drip:	Y	N	P
Polyps:	Y	N	P		Seasonal allergies:	Y	N	P

Mouth/Throat:

Canker sores:	Y	N	P		Sore throat:	Y	N	P
Cold sores:	Y	N	P		Hoarseness:	Y	N	P
Dentures:	Y	N	P		Cavities:	Y	N	P
Loss of taste:	Y	N	P		Gingivitis/Periodontal Disease:	Y	N	P

How often you do you brush your teeth? _____ Floss?_____

What type of brush do you use? _____

How often do you go to the Dentist? _____

Neck:

Stiffness:	Y	N	P	Swollen glands:	Y	N	P
Full movement:	Y	N	P	Tension:	Y	N	P

Respiratory:

Cough:	Y	N	P	TB:	Y	N	P
Wheezing:	Y	N	P	Painful breathing:	Y	N	P
Shortness of breath with exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath sitting:	Y	N	P	Pneumonia:	Y	N	P
Shortness of breath lying down:	Y	N	P	Asthma:	Y	N	P

Cardiovascular:

High blood pressure:	Y	N	P	Rheumatic Fever:	Y	N	P
Low blood pressure:	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest pain:	Y	N	P

Gastrointestinal:

Heartburn:	Y	N	P	Bowel movement frequency: _____			
Indigestion:	Y	N	P	Recent change in BM:	Y	N	P
Bloating:	Y	N	P	Diarrhea or constipation:	Y	N	P
Nausea:	Y	N	P	Hemorrhoids:	Y	N	P
Vomiting:	Y	N	P	Gall bladder disease:	Y	N	P
Change in Appetite:	Y	N	P	Liver disease:	Y	N	P
Pancreatitis:	Y	N	P	Ulcer:	Y	N	P

List all travel outside the US over the last five years: _____

Have you ever had food poisoning?_____

Have you noticed any of the below in your stool or toilet bowl or on toilet paper?

Blood Mucus Undigested Food Black Stool Lighter colored stool

How many antibiotics have you had in your entire life? _____

If you are over 50 y/o, when was your last colonoscopy? _____

Urinary Tract:

Incontinence:	Y	N	P	Pain/burning with urination:	Y	N	P
Frequent infections:	Y	N	P	Kidney stones:	Y	N	P
Urgency:	Y	N	P	Discharge/blood:	Y	N	P

Female Reproductive: IF MALE, PLEASE SKIP

Times Pregnant: _____ Births_____ Miscarriages_____ Abortions_____

Difficulty Getting Pregnant? _____

Do you do a Self Breast exam regularly? Y N How often? _____

Any breast tenderness, lumps, nipple discharge? _____

Age periods began: _____ How often periods occur? _____

How long does the period last? _____

If Menopausal, at what age did it begin? _____

Any problematic menopausal symptoms? _____

If yes, how were/are they treated? _____

Periods:

Heavy Bleeding:	Y	N	P
Clotting:	Y	N	P
Cramping:	Y	N	P
Pain:	Y	N	P
PMS:	Y	N	P
Food Cravings:	Y	N	P
Bloating:	Y	N	P
Irritability:	Y	N	P
Breast tenderness:	Y	N	P

Last Pap Smear: _____

Any abnormal paps? Y N P Date if "Yes":_____

How was that treated? _____

Paps showed HPV negative: Y N Unknown

Mammography: Last Time: _____ Any Concern:_____

Dexa Bone Scan: Last Time:_____Any Bone Loss_____

Use of Hormones Y N P If "Yes" which ones and for What purpose:_____

Are you still on any hormones: _____

Sexual History:

Sexual Orientation:	Heterosexual		Homosexual	Bi-Sexual	Asexual
Sexually Active:	Y	N	P		
Healthy Libido:	Y	N	P		
Sexually Satisfied:	Y	N	P		
Painful Intercourse:	Y	N	P		

Sexually Transmitted Infection: Y N P If "yes", please list: _____

_____

What methods of birth control or safe sex practices are you currently using or interested in using?

_____

Male Reproductive: IF FEMALE, PLEASE SKIP

Prostate:

If over 40, Date of Last Prostate Exam and PSA Blood Work: _____

Problems Starting Urination Y N P

Urination Voiding: Always Complete Mostly Complete Usually Incomplete

Dribbling After Urination: Y N P

BBP/Enlarged Prostate: Y N P

Prostatitis: Y N P

Penile/Scrotal Skin Rash: Y N P

Testicular Pain/Swelling: Y N P

Hernia: Y N P

Penile Discharge: Y N P

Pain/Burning on Urination: Y N P

Sexual Function: Mark any that is positive

Difficulty Achieving Erection: ☐ Difficulty Maintaining Erection: ☐

Premature Ejaculation: ☐ Waking Erection Regularly: ☐

Performance Anxiety: ☐ Concerns of Low Testosterone: ☐

Sexual Orientation: Heterosexual Homosexual Bi-Sexual Other: _____

Method of birth control or safe sex practices are you currently using?_____

Sexually Active: Y N P

Healthy Libido: Y N P

Sexually Satisfied: Y N P

Sexually Transmitted Infection: Y N P If "yes or past" please list: _____

_____

Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P

Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P
TMJ Syndrome: Y N P

Sciatica: Y N P
Carpal tunnel: Y N P
Fainting: Y N P
Disc Disease: Y N P

Mental/Emotional:

Which words best describe you?

Lacking Dreams
Isolated/Lonely
Difficulty Letting Go
Guilty
Frustrated/Angry
Lacking Trust

Without passion or purpose
Lacking Self Worth
Lacking Faith
Judgmental
Impatient
Neurotic/Obsessive

Anticipate Failure
Overly Responsible
Overly Controlling
Self-Critical
Indecisive/No Confidence
Anxious

In A Rush Abuse Victim Memory Problems

Exercise:

Do you have any equipment at home?_____ Do you belong to a gym?_____

What is your history of exercising throughout your life? Always Active Active On/Off Never Active

What types? _____

How many days a week? _____

How long a session? _____

Hobbies: _____

Sleep:

How many hours per night: _____How long does it take you to get to sleep? _____

Do you sleep through the night uninterrupted? Y N

If you wake up regularly, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N Why not:_____

Grinds Teeth: Y N P Sleepwalk: Y N **Snores**: Y N **Apnea**: Y N Unknown

If you have been diagnosed with sleep apnea how are you treating it?_____

Nap During Day: Wants To But Can't Do Not Need To Does Nap At This Time Usually_____

Food:

Appetite Good? Y N P

Do you have constant hunger or do not feel full easily or hungry again soon after eating? Y N

Foods you crave? _____

Foods you dislike? _____

Foods that don't sit well? _____

If on rapid/regular insulin for meals, do you inject 15 minutes before meals? Y N N/A

Toxin Exposure:

Where were you born/lived in life?_____

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?

_____

Have you ever had health problems when you put in new carpeting, painted your home, new cabinets, or did other refurbishing? _____

Are you particularly sensitive to perfumes, gasoline, or other vapors? _____

Do you use pesticides, herbicides, other chemicals around your home? _____

Home Life:

Active Spiritual practice: Y N P

How Happy are you with the direction of your life (1 not happy-10 Very happy)? _____

Do you have a good support network of family/friends? _____

Most Significant Relationship: Healthy/Excellent Unhealthy/Abusive

If abusive, list how: Emotional Physical Other _____

If you have children, good relationship? _____

Do you enjoy your work? _____

How many hours do you work a week?_____

What do you do for fun /stress release? _____

How committed are you towards making valuable changes: Somewhat Moderately Very