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:

Medication	Dose	Times per day	Medication	Dose	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 If no, have you in the past? ☐Yes ☐No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _____

Do you exercise? ☐Yes ☐No If yes, number of times per week?_____

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

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_____