VIGILANT HEALTH
DIABETES CARE

MEDICAL HISTORY

DATE: _____

Answer the following questions with as much detail as possible. This information will help us provide quality care to you.

INFORMATION

☐ MR. ☐ MRS. ☐ MS.	First Name	Middle Initial	Last Name
Street Address	City	State	Zip
Date of Birth	Social Security #	☐ Male ☐ Female	

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ American Indian/Alaska Native ☐ Asian/ Pacific Islander ☐ Black/African American ☐ White ☐ Other	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	☐ English ☐ Spanish ☐ Other

Cell Phone Other Phone	Can We Leave a Message at These Numbers? ☐ Yes ☐ No
E-Mail Address	Can We Send You More Information to This E-Mail Address? ☐ Yes ☐ No
Emergency Contact Name	Emergency Contact Number

Is there a family member, friend, or other person involved in your care or payment that we can share your medical information with
☐ Yes ☐ No

Full Name	Relationship

Who Referred You to Our Clinic

Primary Care Physician (PCP) Name	PCP Phone Number

What Other Doctors Do You See and Why

1. _____ 3. _____
2. _____ 4. _____

DIABETES HISTORY

What type of diabetes do you have	☐ Type 1 Diabetes ☐ Type 2 Diabetes	☐ Prediabetes ☐ Gestational Diabetes	☐ Other

What year were you diagnosed with diabetes or prediabetes

Are you on an insulin pump ☐ Yes ☐ No	Do you have a meter to test your sugar ☐ Yes ☐ No Type

Have you ever had formal education about diabetes (dietitian, classes, etc.) ☐ Yes ☐ No When

What is hard for you about diabetes

Do you follow any special diet for diabetes ☐ Yes ☐ No

RECENT MEDICAL HISTORY

Have You Been in The Hospital or Emergency Room in The Last Six (6) Months ☐ YES ☐ NO

If Yes, Why:

MEDICAL AND SURGICAL HISTORY

CHECK ALL THAT APPLY	
High blood pressure	☐
Cholesterol problems	☐
Heart attack or stent (CAD)	☐
Numbness, pain, ulcers, or amputation of toes, feet or legs from diabetes (Neuropathy)	☐
Kidney problems from diabetes (Nephropathy)	☐
Diabetic eye disease (Retinopathy)	☐
Diabetic stomach problems (Gastroparesis)	☐
Thyroid problems	☐
Other:	☐
Other:	☐
Other:	☐
Other:	☐

LIST ANY SURGERIES YOU HAVE HAD	
Surgery	Year if known
1.	
2.	
3.	
4.	
5.	
6.	

IMMUNIZATIONS

Flu Year: _____

Pneumonia Year: _____

WOMEN ONLY

Number of pregnancies: _____

Number of births: _____ Number of miscarriages or abortions: _____

Did you get diabetes when you were pregnant ☐ Yes ☐ No

Birth control method: _____

Last menstrual period: _____

Are you pregnant ☐ Yes ☐ No

Are you planning on becoming pregnant ☐ Yes ☐ No

SOCIAL HISTORY

Occupation:	
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:
Tobacco Use:	☐ Never Former (Quit _____) ☐ Current Form used: Frequency: Year's use:
Alcohol Use:	☐ Never Former (Quit _____) ☐ Current Type: Frequency: Amount:
Drug Use:	☐ Never Former (Quit _____) ☐ Current Type: Frequency:

FAMILY HISTORY

Check all that apply	Diabetes	Blood pressure	Heart disease	Cancer	Stroke	Thyroid	Unknown
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THESE SYMPTOMS NOW?

YES	NO	CONSTITUTIONAL	YES	NO	EYES
☐	☐	Fevers	☐	☐	Change in vision
☐	☐	Chills	☐	☐	Loss of vision
☐	☐	Night sweats	☐	☐	Double vision
☐	☐	Fatigue	☐	☐	Eye pain
☐	☐	Loss of appetite	☐	☐	Do you wear glasses
☐	☐	Weight loss	☐	☐	Other
☐	☐	Excessive sleepiness in the daytime			
☐	☐	Excessive snoring			
YES	**NO**	**ENT**	**YES**	**NO**	**RESPIRATORY**
☐	☐	Loss of hearing	☐	☐	Cough
☐	☐	Ringing in your ears	☐	☐	Phlegm or sputum
☐	☐	Dizziness/vertigo	☐	☐	Wheezing
☐	☐	Change in your voice	☐	☐	Shortness of breath
☐	☐	Lump or growth on your neck	☐	☐	Coughing up blood
☐	☐	Sinus congestion or drainage	☐	☐	Pain in chest with deep breathing
☐	☐	Sore throat	☐	☐	Other
YES	**NO**	**CARDIOVASCULAR**	**YES**	**NO**	**GASTROINTESTINAL**
☐	☐	Chest pain	☐	☐	Swallowing trouble
☐	☐	Shortness of breath with exercise/exertion	☐	☐	Indigestion
☐	☐	Do you have to sleep propped up on extra pillows at night	☐	☐	Reflux
☐	☐	Do you wake up suddenly short of breath at night	☐	☐	Nausea or vomiting
☐	☐	Do your ankles swell	☐	☐	Abdominal pain or tenderness
☐	☐	Do you black out or faint	☐	☐	Constipation
☐	☐	Does your heart skip beats, beat funny, or go too fast or too slow	☐	☐	Blood stool
☐	☐	Do your calves ache with walking	☐	☐	Black stool
☐	☐	Other	☐	☐	Diarrhea
YES	**NO**	**GENITOURINARY**	**YES**	**NO**	**MUSCULOSKELETAL**
☐	☐	Pain with urination	☐	☐	Muscle pain
☐	☐	Frequency of urination	☐	☐	Muscle tenderness
☐	☐	Urgency to urinate	☐	☐	Joint pain
☐	☐	Blood in urine	☐	☐	Joint tenderness
☐	☐	Kidney stones	☐	☐	Joint swelling
☐	☐	Decrease urinary stream	☐	☐	Other
☐	☐	Do you get up more than 3 times per night to urinate			
☐	☐	Urethral discharge			
☐	☐	Erectile dysfunction			
YES	**NO**	**SKIN**	**YES**	**NO**	**NEUROLOGICAL**
☐	☐	Rash	☐	☐	Numbness or tingling
☐	☐	Itching	☐	☐	Headaches or migraines (circle)
☐	☐	Sores	☐	☐	Weakness
☐	☐	Lumps	☐	☐	Paralysis
YES	**NO**		**YES**	**NO**	
☐	☐	Moles that are changing appearance	☐	☐	Tremor or shakes
☐	☐	Lump in your breast	☐	☐	Walking problems
☐	☐	Tenderness in your breast	☐	☐	Speech problems
☐	☐	Discharge from your breast	☐	☐	Loss of memory

YES	NO	PSYCHIATRIC	YES	NO	ENDOCRINE
☐	☐	Depression	☐	☐	Large volumes of urine
☐	☐	Anxiety	☐	☐	Drinking large volumes of water
☐	☐	Insomnia	☐	☐	Needing to eat all the time
☐	☐	Hallucinations	☐	☐	Blurry vision
☐	☐	Other	☐	☐	Weight gain
			☐	☐	Very hot or cold all the time (circle)
			☐	☐	Abnormal or irregular periods
			☐	☐	Loss of interest in sexual activity
			☐	☐	Swollen glands/lymph nodes
YES	**NO**	**HEMATOLOGICAL**	**YES**	**NO**	**IMMUNOLOGICAL/ALLERGIC**
☐	☐	Easy bruising	☐	☐	Seasonal allergies
☐	☐	Easy bleeding	☐	☐	Hives
☐	☐	Blood clots	☐	☐	Asthma
☐	☐	Low blood counts	☐	☐	Food allergies

MEDICINE

List All Medications and Supplements That You Are Taking (Insulin Is a Medicine)

MEDICINE	DOSE	HOW OFTEN
Pharmacy Name and Address:	Pharmacy Phone Number:	
Do You Have Allergies to Medicines or Foods ☐ Yes ☐ No (If Yes, Please List)		

FORM COMPLETED BY: ☐ **SELF** **OTHER:** _____