HEALTH SUMMARY REPORT

Diabetes Metabolism & Associates

Patient Name: ____________________________ Date of Birth: __________________

Referring Physician: _______________________ Phone: ________________________

Primary Doctor: __________________________ Phone: ________________________

OB/GYN: ________________________________ Phone: ________________________

Pharmacy: _______________________________ Phone: ________________________

Reason for scheduling appointment:

____

Past Medical History: Date:

____

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Past Surgeries: Date:

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Medication List: Dosage:

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Drug Allergies:

____

Family Medical History (not patient): CHECK ALL THAT APPLY

(Please specify: Father, Mother, Sibling, Children, Aunt, Uncle, Grandparent)

	Diabetes	Relationship:		Heart Attack	Relationship:		Other
	Thyroid	Relationship:		Stroke	Relationship:		
	Osteoporosis	Relationship:		High Blood Pressure	Relationship:		
	Cancer	Relationship:		Cholesterol	Relationship:		

Social History:

Occupation: ____

Marital Status: Married Single Divorced Widow Partner Children #: ___________

Tobacco use: Y N Frequency: _________ Previous Smoker? Y N How long: ____

Alcohol use: Y N Frequency: _________ Drug use: Y N Frequency: _________

Complete ONLY if you are Diabetic:

1. Recent Flu Shot: Y N When? ______ 3. Last eye exam? _______
2. Pneumonia Vaccine: Y N When? ______ 4. Last foot exam? _______