SAINT JOHN'S PHYSICIAN PARTNERS
PROVIDENCE

Rose Lin, M.D. Endocrinology
1831 Wilshire Blvd, Suite A, Santa Monica, CA 90403
Phone: 310-829-8584 Fax: 424-291-4205

NEW PATIENT PERSONAL HEALTH HISTORY

REASON FOR DOCTOR'S VISIT: _____

_____

REFERRAL FROM:
Another physician (Name) _____
Friend or another patient (Name) _____
Other (for example referred myself): _____

YOUR MEDICAL HISTORY: Have you been diagnosed with any medical conditions?

YOUR SURGICAL HISTORY: Please list any past surgeries and the year performed.

FAMILY HISTORY

Do any of your family members have:

Diabetes	N	Y	Calcium disorder	N	Y
Thyroid problems	N	Y	Pituitary	N	Y
Heart problems	N	Y	Osteoporosis	N	Y
Stroke	N	Y			
High blood pressure	N	Y	Other:		
High cholesterol	N	Y			
Cancer	N	Y			

SOCIAL HISTORY

Tobacco	Current alcohol intake?	not current	yes/no
never smoked	details:		
former smoker - quit date?	Recreational drug use?	not current	yes/no
current smoker - how much?	details:		
Smokeless Tobacco	Regular exercise regimen?		
never/former/current	details:		

please turn the page to complete side 2

REVIEW OF SYSTEMS: ***Are you currently or recently experiencing any of these problems?***

Fevers or sweats	N	Y	Abdominal Pain	N	Y	Acne	
Chills	N	Y	Nausea	N	Y	Easy bruising	
Weight changes	N	Y	Vomiting	N	Y	Rash	
Fatigue	N	Y	Diarrhea	N	Y	Itching	
Vision problems	N	Y	Constipation	N	Y	Hair changes	
Eye discomfort	N	Y	Pain with urination	N	Y	Joint aches	
Hearing problems	N	Y	Frequent urination	N	Y	Muscle aches	
Nasal congestion	N	Y	Urgent urination	N	Y	Swelling of limbs	
Swallowing difficulty	N	Y	Blood in urine	N	Y	Dry mouth	
Neck swelling or pain	N	Y	Headache	N	Y	Excess thirst	
Chest discomfort	N	Y	Fainting	N	Y	Irregular periods	
Heart palpitations	N	Y	Weakness	N	Y		last period
Short of Breath	N	Y	Balance problems	N	Y	Anxiety	
Coughing	N	Y	Tremors	N	Y	Depression	
Wheezing	N	Y				Sleep difficulty	

ALLERGIES: Do you have allergies to any medications, foods or other substances? What reaction?

CURRENT MEDICATIONS (include non prescription such as vitamins and herbal supplements)

NAME, DOSE (amount), FREQUENCY (when and how many times a day)

Patient signature: _____ **Date:** _____

never

never

N Y

N	Y
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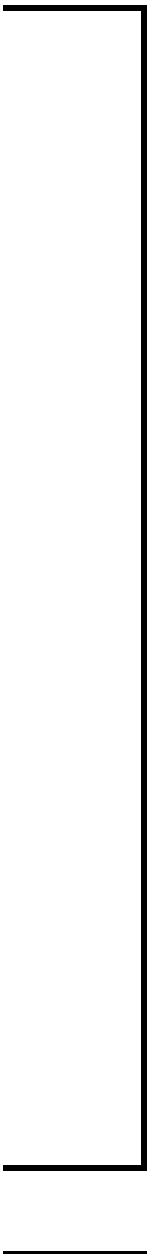

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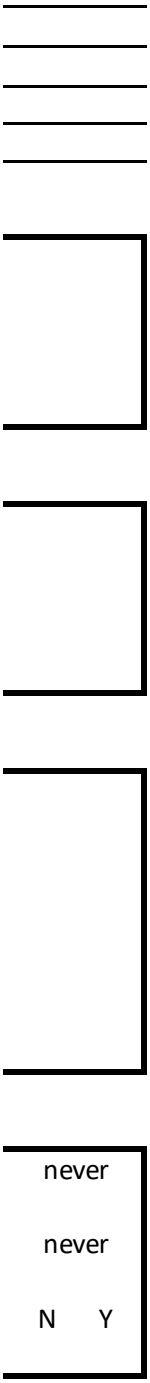
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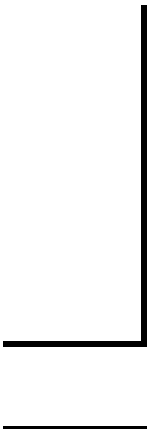

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NEW PATIENT PERSONAL HEALTH HISTORY - DIABETES

YOUR CARE TEAM:
Primary Care Physician: _____
Ophthalmologist/Eye doctor: _____
Nephrologist/Kidney: _____
Cardiologist/Heart: _____
Podiatrist/Foot: _____

YOUR HISTORY:
What was the approximate year or your approximate age when diagnosed with diabetes?

Do you have any of these diabetes related conditions: kidney disease, eye disease, nerve disease?

Have you ever had a heart attack or a stroke? Or any heart problems?

Have you had a diabetic eye exam within the past 1 year?

GLUCOSE MONITORING:
What brand of glucometer do you use?
How many times a day do you test?

HYPOGLYCEMIA:
How often do you have low blood sugar levels, and how low are they?
Is there a pattern to when in the day or night that they occur?

EATING HABITS: Describe your pattern (examples: 3 meals daily; snacking all day; skip meals)

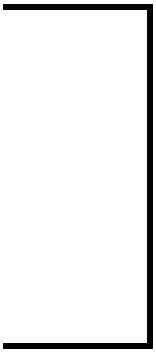
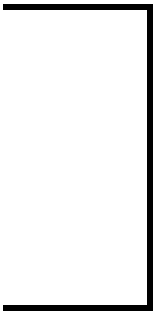
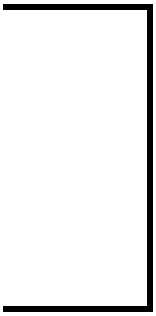
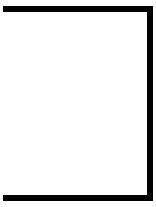
PHYSICAL ACTIVITY: How many times a week and for how long do you exercise?

When was the last time you had a visit with a dietician or certified diabetes educator?

IF APPLICABLE: Please specify brand, and contact our office for instructions on how to set up data sharing

Continuous glucose monitor:

Insulin pump:

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