Sarah Rettinger
1831 Wilshire Blvd., Suite A, Santa Monica, CA 90403
Phone: 310-829-8584

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:		

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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
N	Y
N	Y
N	Y
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N	Y
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N	Y
:	
N	Y
N	Y
N	Y

Rose Lin, M.D. Endocrinology
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N	Y
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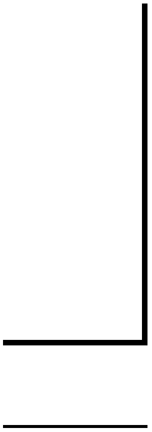

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NEW PATIENT PERSONAL HEALTH HISTORY - DIABETES

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)

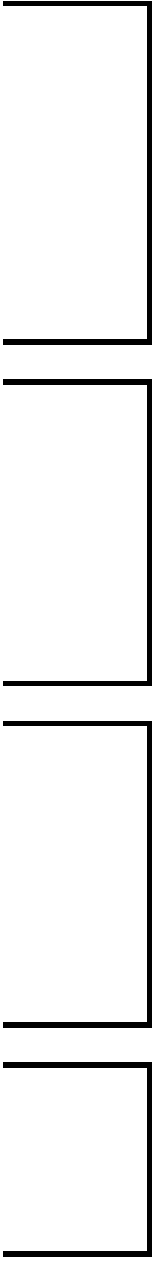
PHYSICAL ACTIVITY: How many times a week and for how long do you exercise?

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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