MEDICAL HISTORY FORM

ID NUMBER: | | | | | | | |

FORM CODE: | M | H | X | G |

DATE: 02/15/2023
Version 1.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

0b. Staff ID: ☐☐☐

A. DIABETES HISTORY

1. At what age were you first told you had diabetes? ☐☐ age in years

2. Have you ever had a low blood sugar (glucose) reaction with symptoms such as sweating, weakness, anxiety, trembling, hunger, or headache?

Yes..... ☐Y
No ..... ☐N → **GO TO ITEM 4**

3. How many times in the last month have you had a low blood sugar (glucose) reaction with symptoms such as sweating, weakness, anxiety, trembling, hunger, or headache? ☐☐

4. Have you ever had severe low blood sugar reactions such as passing out or needing help to treat the reaction (i.e. needing the use of medication or calling EMS or going to the hospital)?

Yes..... ☐Y
No ..... ☐N → **GO TO ITEM 6**

5. How many times in the last year have you had severe low blood sugar reactions such as passing out or needing help to treat the reaction? ☐☐

B. OTHER HEALTH HISTORY

6. What was your weight at age 25? ☐☐☐ lbs

7. Has a doctor ever told you that your diabetes has affected your eyes or that you had retinopathy?

Yes..... ☐Y

No ..... ☐N

8. Has a doctor or other health professional ever said you had peripheral neuropathy or nerve damage in your lower legs, feet, or hands?

Yes..... ☐Y
No ..... ☐N

9. Has a doctor ever said you had any of the following:

	No	Yes
9a. High blood pressure or hypertension	☐N	☐Y
9b. High blood cholesterol	☐N	☐Y
9c. Heart attack	☐N	☐Y
9d. Stroke	☐N	☐Y
9e. Cancer	☐N	☐Y
9f. Atrial fibrillation	☐N	☐Y
9g. Heart failure	☐N	☐Y

C. FAMILY HISTORY

10. Did your biological mother ever have or does she now have any of the following diseases:

	No	Yes	
10a.Diabetes	☐N	☐Y →	**If yes, answer 11a**
10b.High blood pressure or hypertension	☐N	☐Y →	**If yes, answer 11b**
10c.Stroke	☐N	☐Y →	**If yes, answer 11c**
10d.Heart attack	☐N	☐Y →	**If yes, answer 11d**

11. Approximately how old was she when she was first told she had:

11a.Diabetes	☐☐	age in years
11b.High blood pressure or hypertension	☐☐	age in years
11c.Stroke	☐☐	age in years
11d.Heart Attack	☐☐	age in years

12. Did your biological father ever have or does he now have any of the following diseases:

	No	Yes	
12a.Diabetes	☐N	☐Y →	**If yes, answer 13a**
12b.High blood pressure or hypertension	☐N	☐Y →	**If yes, answer 13b**
12c.Stroke	☐N	☐Y →	**If yes, answer 13c**
12d.Heart attack	☐N	☐Y →	**If yes, answer 13d**

13. Approximately how old was he when he was first told he had:

13a.Diabetes	☐☐	age in years
13b.High blood pressure or hypertension	☐☐	age in years
13c.Stroke	☐☐	age in years
13d.Heart Attack	☐☐	age in years

D. DIABETES MEDICATION USE

14. Are you taking insulin?

Yes..... ☐Y
No ..... ☐N

15. Are you now taking diabetic pills to lower your blood sugar? These are sometimes called oral agents or oral hypoglycemic agents.

Yes..... ☐Y
No ..... ☐N

E. HEART FAILURE SYMPTOMS

16. Have you had to sleep on 2 or more pillows to help you breathe?

Yes..... ☐Y
No ..... ☐N

17. Have you been awakened at night by trouble breathing?

Yes..... ☐Y
No ..... ☐N

18. Have you had swelling of your feet or ankles (excluding during pregnancy)?

Yes..... ☐Y
No ..... ☐N → **GO TO ITEM 19**

18a. Did the swelling tend to come on during the day and go down overnight?

Yes..... ☐Y
No ..... ☐N

F. NEUROLOGY

19. Have you ever had a head injury that resulted in loss of consciousness?

Yes..... ☐Y
No ..... ☐N→ **GO TO ITEM 20**

19a. Have you had a head injury with extended loss consciousness for more than 5 minutes?

Yes..... ☐Y
No ..... ☐N

19b. Have you had a head injury that resulted in long-term problems or dysfunction?

Yes..... ☐Y
No ..... ☐N

20. Have you ever had a seizure or convulsion?

Yes..... ☐Y
No ..... ☐N→ **GO TO ITEM 21**

20a. Have you ever been treated with anti-seizure medications?

Yes..... ☐Y
No ..... ☐N

21. Have you ever been told by a doctor or health professional that you had/have Multiple Sclerosis?

Yes..... ☐Y
No ..... ☐N

22. Have you ever been told by a doctor or health professional that you had/have a brain tumor?

Yes..... ☐Y
No ..... ☐N

23. Have you ever been told by a doctor or health professional that you had/have “migraine” headaches?

Yes..... ☐Y
No ..... ☐N