Patient Name: _____ Today's Date: _____

EMMC Initial Patient History

Personal History

Age: _____ Height: Feet _____ Inches _____

Weight: Current Weight _____ Goal Weight _____

Marital Status: Married Single Divorced Separated Widowed

Referred by:

Presenting Problems

What symptoms are you experiencing at this time?

Current Medications (Insulin further down page)

Medicines

Name	Dose	How Often?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Insulin

Time	Amount/Type	Amount/Type
Example	50 units NPH	10 units Reg
Breakfast:		
Lunch:		
Dinner:		

Patient Name: _____ Today's Date: _____

Insulin cont.

Bedtime:
Other:
Do you use an insulin Pump? ☐ Yes ☐ No
Make and model of pump:

Allergies to Medication

Name	Reaction
1	
2.	
3.	
4.	

Food Allergies (please circle one): Yes No

Medical History

Condition	(Circle one)		If yes, year of diagnosis
High Cholesterol:	Yes	No	
Hypertension	Yes	No	
Glaucoma	Yes	No	
Liver Disease	Yes	No	
Kidney Disease	Yes	No	
Anorexia/Bulimia	Yes	No	
Heart Disease	Yes	No	
Thyroid Disorder	Yes	No	
Diabetes	Yes	No	

How often do you test blood sugars?

Breakfast: _____ Lunch: _____ Dinner: _____ Bedtime _____

Osteoporosis	Yes	No	
Bowel Disorder(s)	Yes	No	
Insomnia	Yes	No	
Seizures	Yes	No	

Other _____

Surgical History (please list)

Year	Type of Surgery	Attending Physician and Hospital
1.		
2.		

Patient Name: _____ Today's Date: _____

Recent Hospitalizations (please circle one) – Yes No

Date	Diagnosis
1.	
2.	

Social History &

Do you smoke? ☐ Yes ☐ No How much? _____ packs per day

Do you drink alcohol? ☐ Yes ☐ No How much? _____ per day / week / month

Type of alcohol _____

Do you use recreational drugs? ☐ Yes ☐ No How much? _____ per day / week / month

Type of drug _____

Family History

Are you adopted? ☐ Yes ☐ No

Family Member	Age	Medical Conditions
Mother		
Father		
Brother(s)		
Sister(s)		

Exercise

Do you exercise? ☐ Yes ☐ No Type of exercise _____

How often do you exercise? _____ minutes / hours _____ Daily / weekly

Diet

Do you follow a special diet? ☐ Yes ☐ No Comments: _____

Physician Information

Primary Care Physician _____

Address _____

Phone _____ Fax _____ E-mail Address _____

Additional Doctors Name, Address, and Fax Number to mail or fax your chart notes to:

_____

_____