

**St. Francis Diabetes & Endocrinology Center
Adult Historical Summary**

Name _____ Date of Birth _____ Sex: M or F Physician _____

Reason for visit _____

Patient History

List any previously diagnosed illnesses / conditions:

- | | |
|---------------------|---------------------|
| 1. _____ date _____ | 2. _____ date _____ |
| 3. _____ date _____ | 4. _____ date _____ |
| 5. _____ date _____ | 6. _____ date _____ |

List any hospitalizations / surgeries / invasive procedures:

- | | |
|---------------------|---------------------|
| 1. _____ date _____ | 2. _____ date _____ |
| 3. _____ date _____ | 4. _____ date _____ |
| 5. _____ date _____ | 6. _____ date _____ |

Family History

Father: living dead age at death (if applicable) _____ cause of death (if applicable) _____
 Mother: living dead age at death (if applicable) _____ cause of death (if applicable) _____

Have you had a family member with any of the following? If so, check the appropriate box.

	Father	Mother	Children	Brothers/ Sisters	Grandparents		Father	Mother	Children	Brothers/ Sisters	Grandparents
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	genetic disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bone fractures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
high cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	calcium problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have an advance directive? Yes No **If yes,** living will, durable power of attorney, health care directive.
Would you like information about advance directives? Yes No {Staff Use : Brochure given date/ initials _____}
 * **If you have an advance directive please provide the office with a copy**

Social History

Marital Status : _____ Children (list name & ages): _____
 Do you live alone? yes no If you needed help to care for yourself, is there someone available to help you? yes no
 Tobacco use: presently yes no If yes, how much/day _____ x _____ years past: yes no date stopped: _____
 Recreational drugs use: yes no Alcohol: yes no If yes, type _____, how much _____ / day _____ / week
 Do you exercise: yes no type: _____ number of times/ week _____ length of time exercised _____
 Caffeine: yes no If yes, how much / day _____ Do you eat? red meats, how much / week _____
 ;
 Fried foods, how much / week _____. Do you follow a diabetic diet? If so, which one _____
 Occupation: _____ Special interests / hobbies: _____

Factors That May Affect Learning

Who is to be taught: patient other; if other, relationship to patient _____
Able to read: yes no with difficulty Comments _____
Potential barriers to learning: none blind poor vision deaf decreased hearing unable to talk learning disability inability to understand memory loss language, if other than English _____ **Learns best by:** reading
 verbal instruction practicing talking watching other, _____ **Are there any cultural or religious beliefs that need to be considered in the care?** yes no. If yes, _____

Signature _____ Relationship to patient _____ Date _____

Staff review: date / initials _____ date / initials _____ date / initials _____ date / initials _____
 date / initials _____ date / initials _____ date / initials _____ date / initials _____