Demographics Form Hanson Diabetes Center ADA# 003542 Tel: 941-624-4800

How did you hear about us? ☐ Internet ☐ Ad ☐ Primary physician ☐ Specialist ☐ word of mouth
☐ Patient in practice ☐ Hospital ☐ Insurance company Other _____

PATIENT INFORMATION:

Patient's Name (Last, First, MI): _____

Primary Care Provider Name: _____

Date of Birth: _____Age: _____ Sex: ☐ M ☐ F ☐ Transgender

Cell Phone Number: _____ Other Phone ☐ home or ☐ work: _____

Contact preference: ☐ cell phone ☐ Home phone ☐ work phone ☐ Text Message

Check message okay to leave on voicemail: ☐ Billing info ☐ Medical info ☐ Email / Patient Portal

E-Mail Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Alternate address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ ☐ Student ☐ Retired ☐ Disabled ☐ Not employed

Primary language spoken: ☐ English ☐ Spanish ☐ Creole other: _____

RACE: ☐ I decline giving information on my race and ethnicity

☐ Caucasian /White ☐ African American ☐ Asian ☐ American Indian Other: _____

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic Other: _____

INSURANCE INFO -PATIENT IS SUBSCRIBER We will scan your ID and insurance card

Primary Insurance: _____

Secondary Insurance: _____

INSURED INFO (IF OTHER THAN PATIENT IS SUBSCRIBER)

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Policy Number: _____ Date of Birth: _____

His or Her Employer: _____ Work Phone: _____

EMERGENCY CONTACT:

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Name(s): _____ Phone: _____Relationship: _____

Name(s): _____ Phone: _____Relationship: _____

Health History Form Hanson Diabetes Center ADA# 003542 Tel: 941-624-4800

NAME: _____ Primary care doctor: _____

Current Weight _____lbs Height _____

MEDICATIONS / Herbals / OTC Diabetics please write diabetes meds on the Diabetes History page. May provide a list to staff instead of completing this section.

_____

_____

Local Pharmacy _____ Mail Order:_____

List Any Known Allergies: _____

Current / Past Job title: _____ ☐ Retired ☐ Employed ☐ Student Are you on disability? ☐ No ☐ Yes, Reason _____

Medical History: please check your past and present problems and insert onset dates.

Condition	Onset Date	Condition	Onset Date
☐ Alcoholism		☐Heart Attack	
☐ Allergies		☐HIV	
☐ Amputation		☐High Cholesterol	
☐ Anemia		☐High Blood Pressure	
☐ Anxiety		☐Kidney Disease	
☐Arthritis		☐Kidney Stones	
☐Asthma		☐Liver Disease	
☐Atrial Fibrillation		☐Macular Degeneration	
☐Blood Clot		☐Neuropathy	
☐Cancer Cancer Type			
☐Carotid Artery Disease		☐Osteopenia	
☐Cataracts		☐Osteoporosis	
☐Colitis		☐Pancreatitis	
☐Congestive Heart Failure		☐Peptic Ulcer Disease	
☐COPD/ Emphysema		☐Poor Circulation / PVD	
☐Dementia / Memory Loss		☐Pneumonia	
☐Depression		☐Pre-Diabetes	
☐Diabetes		☐Psoriasis	
☐Enlarged Prostate		☐Retinopathy	
☐Eczema		☐Sleep Apnea	
☐Fractures		☐Stomach/Colon Disease	
☐Gastroparesis		☐Thyroid Disorder	
☐Gestational Diabetes		☐TIA / Stroke	
☐ Glaucoma		☐Tuberculosis	
☐ Gout		☐ Ulcers – leg or foot	
☐ Hives / urticaria			

NAME: _____ Age: _____

Surgical History (Check all that apply) ☐ None

Surgery	Date	Surgery	Date
☐Appendectomy		☐Hysterectomy	
☐ Bypass Surgery - Leg		☐Knee Replacement Right Left	
☐Biopsy Type		☐Laminectomy	
☐ Cataracts Right Left		☐Pacemaker/Defibrillator	
☐ Cervical spine fusion		☐Shoulder Surgery Right Left	
☐ Coronary artery stent		☐Skin Lesions Removed Type	
☐ Coronary Artery Bypass Grafting (CABG)		☐Thyroidectomy	
☐ Cholecystectomy (Gallbladder)		☐Tonsillectomy	
☐Hernia Repair		☐Vasectomy	
☐ Hip replacement Right Left		☐Other	

Family History ☐ unknown ☐ None

Condition	Mother	Father	Sister	Brother	Daughter	Son
☐Arthritis						
☐Asthma						
☐Dementia						
☐Depression						
Diabetes						
☐Heart Disease						
☐High Blood Pressure						
☐High Cholesterol						
☐Kidney Disease						
☐Obesity						
☐Osteoporosis						
☐Stroke						
☐Cancer						
☐Cancer Type						
☐Other (list below)						
DECEASED						

Family History Comments: _____

TOBACCO USE: please place check mark where appropriate

Do you smoke tobacco? ☐ Never smoked ☐ Every day smoker ☐ Some day smoker

☐ Former smoker quit date_____

NAME: _____ Age: _____

ALCOHOL: please place check mark where appropriate
How much do you drink? ☐ None ☐ Socially ☐ Moderate ☐ Daily ☐ Quit date: _____
Type of Alcohol: ☐Beer ☐ Wine ☐ Hard liquor

Physical Activity level: ☐ **inactive** (house work only) ☐ **insufficiently active** (less than 150 minutes a week) ☐ **active** (150 – 300 minutes a week) ☐ **highly active** (more than 300 minutes a week)
What type of physical activity do you do? ☐ Gym _____

Fall Risk >age 65 *(CPT 3288F, 1100F, 1101F):* Have you had any falls within the past year? ☐ None
☐ had multiple falls ☐ had at least 1 fall with injury **Any gait or balance problems:** ☐ No ☐ Yes

HealthCare Team	**Name of Provider**	**Date of last visit**
Primary Care Provider		
Foot Doctor		
Heart Doctor		
Kidney Doctor		
Eye Doctor		
Other (Specify)		

Annual Screening	**Test done**	**Date(s) done**	**Results**	**Reason not done**
Breast cancer screen age 50 - 74	Mammogram		__normal __abnormal	☐Declined ☐bilateral mastectomy
Colorectal screen age 50 - 75	__Colonoscopy __Stool occult		__Negative __positive	☐Declined
Osteoporosis screen	Bone Density		__normal __abnormal	
Depression screen *(no history of Depression)*	PHQ-2		__Negative __positive	☐Declined ☐poor cognition
Flu Vaccine *(season Aug 1st - March 31st)*				☐Declined ☐allergic ☐Vaccine not available
Pneumonia Vaccine				☐Declined
COVID vaccine	__Moderna __Pfizer __J and J			☐Declined

PLEASE READ AND SIGN BELOW: To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any change in my medical status.

_____ _____
Signature of patient, parent, guardian Date
Thank you for taking the time to complete <u>all</u> pages of this form. This helps us to better serve you!

Name: _____ Date: _____

COMPREHENSIVE REVIEW OF SYSTEMS: please check off all current symptoms

CONST: ☐ weight gain ☐ weight loss ☐ fatigue ☐ night sweats
EYES: ☐ double vision ☐ blurred vision ☐ legally blind
ENMT: ☐ hearing loss ☐ hoarseness ☐ difficulty swallowing ☐ sinus problems ☐ neck pain/tenderness ☐ neck swelling /lump ☐ Dentures
HEART/CV: ☐ chest pain ☐ fast heart beat (palpitations) ☐ calf pain on walking ☐ swelling leg/feet
RESP: ☐ wheezing ☐ snoring ☐ cough ☐ shortness of breath
GI: ☐ constipation ☐ diarrhea ☐ nausea or vomiting ☐ abdominal bloating ☐ decreased appetite ☐ heartburn / reflux
GU: ☐ frequent urination ☐ urine incontinence ☐ decreased libido ☐ erection problem ☐ breast discharge ☐ breast pain **Female Reproductive:** ☐ Abnormal Periods ☐ Breast Discharge ☐ Breast Pain
MUSCULOSKELETAL: ☐ muscle aches ☐ muscle cramps ☐ weakness ☐ neck pain ☐ joint pain/swelling ☐ back pain ☐ Deformity
SKIN: ☐ Fragile Nails or Discoloration ☐ dry skin ☐ rash
NEURO: ☐ memory problem ☐ dizziness ☐ headaches ☐ Poor balance ☐ Numbness hands or feet ☐ Tingling hands or feet ☐ tremors
PSY: ☐ anxiety ☐ irritable mood ☐ depression ☐ trouble sleeping ☐ Sleep too much
ENDO: ☐ hot flashes ☐ excess sweating ☐ always cold ☐ excess hunger ☐ hair loss ☐ excess hair
HEMATOLOGIC: ☐ Bruise easily ☐ Enlarged Lymph Nodes
Please list any other symptoms: