TuftsMedicine
Lowell General Hospital

Diabetes and Endocrine Center
9 Loon Hill Road
Suite 301
Dracut, MA 01826

Thank you for choosing Tufts Medicine Lowell General Hospital Diabetes and Endocrine Center. Please fill out this form completely so we may provide excellent healthcare to you. We may ask you to update this information in the future to ensure your information is kept up to date.

| | |
|---|---|
| Patient Name:<br>Last First MI | Date of Birth:<br>Patient's Social Security #: |
| Address | City State Zip Code |
| Home Phone: Cell Phone:<br>Preferred Contact #: | Patient's Email:<br>Ethnicity: Race: |
| Sex:<br>Female Male Transgender | Marital Status:<br>Single Married Separated<br>Divorced Partner Widowed |
| Student:<br>Full Time Part Time Not Student | Parent/Legal Guardian Name:<br>Phone Number: |
| Occupation:<br>How long have you been with employer: | Employer: |
| Emergency Contact Name/Relation | Emergency Contact Phone Number: |
| Primary Care Physician:<br>Phone Number: | Primary Care Physician Address: |
| Referring Physician:<br>Phone Number: | Referring Physician Address: |
| Preferred Pharmacy:<br>Phone Number: | Preferred Pharmacy Address: |

**MEDICAL QUESTIONNAIRE**

Please list your reason(s) for your visit:

| |
|---|
| 1. |
| 2. |
| 3. |

Please provide us a list of medications you are currently taking, both prescribed and over the counter medicines. Please remember to inform us at each visit any new medications you are taking or medications you have stopped taking.

| Medication/Dose | Frequency |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Please list any surgeries or hospitalizations you have had.

Surgery/Hospitalization: ____________________________________________ Date: _______________

Surgery/Hospitalization: ____________________________________________ Date: _______________

Surgery/Hospitalization: ____________________________________________ Date: _______________

Surgery/Hospitalization: ____________________________________________ Date: _______________

Please list social history

Drinks per week__________ Coffee/Tea per week__________ Sodas per week__________
(Alcohol: Beer, Wine, Hard Liquor)

Exercise Regularly__________ Type of exercise___________________________ Frequency_______________

Level of education_______________

Tobacco products per day___________ Number of years smoking__________ Quit date (if applicable) ________

Marijuana use: YES NO How many times per day__________ Number of years___________

Please list all allergies and the reaction you experienced.

1.______________________________________________ Reaction: ____________________________________

2.______________________________________________ Reaction: ____________________________________

3.______________________________________________ Reaction: ____________________________________

4.______________________________________________ Reaction: ____________________________________

**HEALTH HISTORY FORM**

Please check all that apply to you

| | Yes | No |
|---|---|---|
| Chest Pain | | |
| Swollen ankles | | |
| Shortness of Breath | | |
| Recent weight loss, fever, night sweats | | |
| Persistent cough, coughing up blood | | |
| Bleeding problems, Bruising easily | | |
| Sinus problems | | |
| Difficulty swallowing | | |
| Diarrhea, constipation, blood in stool | | |
| Frequent vomiting, nausea | | |
| Change of appetite | | |
| Neck, back or joint pain | | |
| Muscle weakness, cramps | | |
| Headaches | | |
| Hoarseness, sore throat | | |
| Blurred vision | | |
| Seizures | | |
| Excessive thirst | | |
| Frequent urination | | |
| Significant fatigue | | |
| Rashes or skin problems | | |
| Joint pain, stiffness | | |
| Heart Disease | | |
| Pancreatitis | | |

| | Yes | No |
|---|---|---|
| Heat Attack, Heart defects | | |
| Heart Murmurs | | |
| Stroke, hardening of arteries | | |
| High blood pressure | | |
| Low blood pressure | | |
| Thyroid disease | | |
| Hepatitis, other liver diseases | | |
| Stomach problems, ulcers | | |
| Head & neck radiation | | |
| Tumors, cancer | | |
| Adrenal disease | | |
| Eye disease | | |
| Numbness, tingling, pain in legs, feet, hands | | |
| Anemia | | |
| High cholesterol, triglycerides | | |
| Osteopenia or Osteoporosis | | |
| Kidney, bladder disease | | |
| Diabetes | | |
| **WOMEN ONLY** | | |
| Regular periods | | |
| Breast swelling | | |
| Menopause | | |
| Nipple Discharge | | |
| **MEN ONLY** | | |
| Impotence | | |
| Loss of sex drive | | |

If you have had any of the following, please list the date and name of doctor performed/received by

| | DATE | DOCTOR |
|---|---|---|
| EKG | | |
| Dilated eye exam | | |
| Stress Test | | |
| Diabetes Education | | |
| Pneumonia Vaccine | | |
| Flu Vaccine | | |

**COVID Vaccine**

| Vaccine | Date | Pfizer/Moderna |
|---|---|---|
| 1st vaccine | | |
| 2nd vaccine | | |
| 1st booster | | |
| 2nd booster | | |

## FAMILY HISTORY

Please put a check mark by all that apply

| | Mother | Father | Brother | Sister | Grandparent | Other |
|---|---|---|---|---|---|---|
| Age (if living) | | | | | | |
| Health (G) good (B) bad | | | | | | |
| Cancer | | | | | | |
| Tuberculosis | | | | | | |
| Diabetes | | | | | | |
| Heart Disease | | | | | | |
| High blood pressure | | | | | | |
| Stroke | | | | | | |
| Epilepsy | | | | | | |
| Nervous breakdown | | | | | | |
| Asthma, hives, hay fever | | | | | | |
| Blood disorder | | | | | | |
| High cholesterol | | | | | | |
| Thyroid disease | | | | | | |
| Adrenal disease | | | | | | |
| Pituitary disease | | | | | | |
| Other health issues not listed | | | | | | |
| Age (at death) | | | | | | |
| Cause of death | | | | | | |