OppenheimerEndocrinology
DIABETES & THYROID CARE

Patient/Family Profile

History No. _____

Date _____

PATIENT
NAME _____ Name of Spouse _____
(Last) (First) (Middle)

INFORMATION GIVEN BY: _____ Relationship to Patient _____

Birthdate: _____ Age: _____ Sex: _____

MARITAL STATUS: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Number of children: _____

Allergies: To Medications (list) _____

Other Allergies _____

Have you or your family member ever had or currently have any of the listed problems? "Family member" includes: children, grandparent, parent, brother, sister, aunt or uncle.

	Patient	Family Member	Relationship		Patient	Family Member	Relationship
High Blood Pressure	❑	❑	_____	Hearing Disorder	❑	❑	_____
Heart Problems	❑	❑	_____	Fainting Spells	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Epilepsy	❑	❑	_____
Rheumatism or Arthritis	❑	❑	_____	Severe headaches	❑	❑	_____
Kidney Problems	❑	❑	_____	Mental/Nervous Disorder	❑	❑	_____
Stomach Problems	❑	❑	_____	Rupture or Hernia	❑	❑	_____
Ulcer Problems	❑	❑	_____	Prostate Problems	❑	❑	_____
Diabetes	❑	❑	_____	Skin conditions or	❑	❑	_____
Asthma	❑	❑	_____	Chronic Rash	❑	❑	_____
Hay Fever	❑	❑	_____	Gallbladder Problems	❑	❑	_____
Allergies	❑	❑	_____	Dislocation of Joints	❑	❑	_____
Shortness Of Breath	❑	❑	_____	Fractures	❑	❑	_____
Lung Problems	❑	❑	_____	Back Pain	❑	❑	_____
Anemia	❑	❑	_____	Back Injury	❑	❑	_____
Varicose Veins	❑	❑	_____	Knee Injury	❑	❑	_____
Cancer	❑	❑	_____	Head Injury	❑	❑	_____
Type _____	❑	❑	_____	Complications,	❑	❑	_____
Tumor	❑	❑	_____	Childhood Diseases	❑	❑	_____
Type _____	❑	❑	_____	Glaucoma	❑	❑	_____
Vision Problems	❑	❑	_____	Thyroid	❑	❑	_____

Other: _____

Hospitalizations: Date: _____ Problem: _____

Date: _____ Problem: _____

Which doctor are you seeing today? _____

Are you at present under a doctor's care for any condition? ❑ Yes ❑ No

Are you taking any medication at this time? ❑ Yes ❑ No If so, what? _____

_____

_____

Do you smoke? ❑ Yes ❑ No Have you ever smoked? ❑ Yes ❑ No

Do you use alcohol? ❑ Yes ❑ No

Date of last chest x-ray: _____

(FEMALE PATIENT)

Menstrual Cycle: Regular _____ Irregular _____ Problems: _____

No. Of Pregnancies: _____ No. of Living Children: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ D.O.B. _____ Med Record # _____

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully.

I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling **(605) 275-6525**.

Patient/Legal Guardian Signature: _____ Date: _____