**Muscogee (Creek) Nation Clinics**

**Medical History Update**

Muscogee Creek Nation Health System

**Diabetes Program**

**Medical History Update**

Were you in the hospital the past year? Yes / No

If yes, what was the reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the past two weeks, have you felt down, depressed or hopeless? Circle: Yes / No

In the past two weeks, have you felt little interest or pleasure in doing things? Circle: Yes / No

Have you had any of the following problems in the **past year?**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_Leg cramps | \_\_\_\_\_Problems seeing things | \_\_\_\_\_Skin infections |
| \_\_\_\_Unexplained Weight loss | \_\_\_\_\_Burning feet | \_\_\_\_\_Very thirsty |
| \_\_\_\_Unexplained Weight gain | \_\_\_\_\_Passing lots of urine | \_\_\_\_\_Very tired |

Do you have or have you had any of the following problems in the **past year?**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_Bleeding in eye |  Shortness of Breath | \_\_\_\_\_Athletes’ feet |
| \_\_\_\_\_Eye surgery | \_\_\_\_\_Vomiting | \_\_\_\_\_Kidney infection |
| \_\_\_\_\_Cataracts | \_\_\_\_\_Diarrhea | \_\_\_\_\_Protein in urine |
| \_\_\_\_\_Glaucoma | \_\_\_\_\_Constipation |  One-sided weakness |
| \_\_\_\_\_Blindness | \_\_\_\_\_Dizziness | \_\_\_\_\_Trouble with sex |

Do you have or have you had problems with the following in the **past year:**

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_Head | \_\_\_\_\_Thyroid | \_\_\_\_\_Kidneys/bladder |
| \_\_\_\_\_Eyes | \_\_\_\_\_Lungs | \_\_\_\_\_Prostate |
| \_\_\_\_\_Face | \_\_\_\_\_Heart | \_\_\_\_\_Female problems |
| \_\_\_\_\_Mouth | \_\_\_\_\_Breasts | \_\_\_\_\_Hips, Legs, Knees |
| \_\_\_\_\_Teeth/Gums | \_\_\_\_\_Stomach | \_\_\_\_\_Shoulder, Arms, Hands |
| \_\_\_\_\_Ears or hearing | \_\_\_\_\_Bowels | \_\_\_\_\_Feet |
| \_\_\_\_\_Throat | \_\_\_\_\_Gallbladder | \_\_\_\_\_Drug Allergies |
| \_\_\_\_\_Neck | \_\_\_\_\_Back | \_\_\_\_\_Other Allergies |
| \_\_\_\_\_Anemia | \_\_\_\_\_Tuberculosis | \_\_\_\_\_Emotional/Mental Illness |
| \_\_\_\_\_Skin | \_\_\_\_\_Epilepsy/Seizures | \_\_\_\_\_Liver/Hepatitis |

**Other Health Risks:**

How often do you drink more than 2 alcoholic beverages in one day? Please circle:

[ ]  5-7 days a week [ ]  Weekends only [ ]  1 time a month [ ]  Less than 3 times/year [ ]  None.

Do you use tobacco? [ ]  Cigarettes, Pks/Day \_\_\_ [ ]  Cigars or Pipe [ ]  Dip or Chew

If you have quit smoking, how long has it been since you quit? \_\_\_\_\_\_

Have you been told that you snore loudly or have periods of not breathing during sleep? Yes / No

Do you have difficulty staying awake during the day or feel extremely tired? Yes / No

**Health Care Use:**

When you have a health problem, where do you usually go first? Please check.

[ ]  IHS clinic; [ ]  IHS emergency room; [ ]  Tribal clinic; [ ]  Okemah Emergency Room [ ]  Other

Please give location if other than this clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Signature/Title Date**

**Patient Identification:**