DIABETES NEW PATIENT FORM

Name:_____ Primary Care Physician: _____

What is the best way to contact you: ☐ **Phone** _____ **OR** ☐ **Email: Follow My Health**

If by phone, can we leave a detailed message: ☐ **Yes** ☐ **No**

Retail Pharmacy: _____ **Mail Order Pharmacy:** _____

DIABETES HISTORY: Pease answer the questions below:

What type of Diabetes do you have: ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Unknown

At what age was your diabetes diagnosed? _____

Meter name: _____ **Pump name:**_____

Do you check your blood sugars at home? □ **Yes** □ **No**

How many times a day do you check? _____ **Do you keep a blood sugar log?** □ **Yes** □ **No**

What is your recent blood glucose level before you ate breakfast this morning? _____

Do you ever have low blood sugars (below 70mg/dl)? _____ **If yes, please answer the following:**

Do you have symptoms when your blood sugars go low? _____

Have you ever been hospitalized for low blood sugars? _____

Have you been hospitalized for high blood sugars or had DKA? _____

Have you ever seen a dietitian? □ **Yes** □ **No**

If yes, when was the most recent visit? _____

How well do you follow your diabetic diet? ☐**Good** ☐**Not very good** ☐**Poor**

Do you work night-shift: ☐**Yes (please list work hours**_____**)** ☐**No**

Do you have any diabetes-related complications?

□ **Eye problems:** _____ **Last Eye Exam:** _____

□ **Foot problems:** _____ **Last Foot Exam:** _____

□ **Kidney problems:** _____ **Name of your Nephrologist (kidney doctor):**_____

□ **Heart problems:** _____ **Name of your Cardiologist (heart doctor):**_____

Review of Systems: Check any of those problems which you are currently experiencing:

General
- ☐ Weight changes Amount: _____
- ☐ Fatigue
- ☐ Fever
- ☐ Chills

Skin
- ☐ Skin Rash
- ☐ Itchiness
- ☐ Purple stretch marks
- ☐ Darkened skin areas

Eyes
- ☐ Double or blurred vision
- ☐ Eye Irritation
- ☐ Bulging/Swelling of Eyes
- ☐ Diabetic Retinopathy

Cardiovascular
- ☐ Pain in chest
- ☐ Palpitations (racing heart)
- ☐ Leg Swelling (Edema)

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Increasing constipation
- ☐ Stomach pain

Genitourinary
- ☐ Frequent urination
- ☐ Sexual dysfunction
- ☐ Irregular Menses

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle Pains

Neurological
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness or sensitivity of feet/fingers
- ☐ Dizziness/ Light headedness
- ☐ Fainting

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Endocrine
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hair growth
- ☐ Hair loss
- ☐ Goiter
- ☐ Breast/Nipple Discharge
- ☐ Change in hand/ring size or shoe size

For Women Only:

Age when periods began:_____

Periods regular? □ Yes □ No

Have you gone through menopause? □ Yes (age: _____) □ No

Do you plan to get pregnant in the near future? □ Yes □ No

Number of pregnancies? _____

Number of miscarriages? _____

Social History:

Are you married or with a partner? _____ Do you have any children? _____

Occupation: _____

Do you exercise? □ Yes □ No

If yes, how many days per week at a moderate level (like a brisk walk) or greater: _____

How many minutes each time: _____

Do you smoke tobacco? □ Yes (per day:_____) □ Former □ No

Do you drink any alcohol? □ Yes (drinks per day:_____) □ Former □ No

Do you use recreational drugs? □ Yes (type:_____) □ Former □ No

You do not need to fill this page out if the information is already in your electronic chart

MEDICAL HISTORY: Check if you have (or had in the past) any of the following conditions:

	Pertinent details (date diagnosed, type of condition, etc.)
High Blood Pressure	
High Cholesterol	
Heart Problems or Bypass Surgery	
Stroke	
Thyroid Problems	
Kidney Problems	
Osteoporosis	
Cancer	
Other	

Please list any surgeries you have had:

Type of Surgery and Date:

Medication Allergy:

Please list your medications: (include supplements, herbal medicines, vitamins)

FAMILY HISTORY: check if any of your family members have any of the following conditions:

	Yes	No	Which Family Member, any details
Diabetes			
High Blood Pressure			
High Cholesterol			
Heart Problems or Bypass Surgery			
Stroke			
Thyroid Problems			
Kidney Problems			
Osteoporosis			
Cancer			
Other			