Endocrine & Metabolic Health Services New Patient intake Form
Diabetes

Name:

Date of Birth:

1. Who may we thank for referring you to our clinic? .

.

2. What is your chief concern that you would like addressed today? .

.

3. What year were you diagnosed with diabetes? .

.

4. If you are on insulin, what year did you start it? .

.

5. What is your insulin regimen (what type of insulin, how much, how often):

6. What other diabetes medications do you currently take (include how much you take and how often)

7. Please write below any diabetes drugs you previously took, but do not take any longer:

8. How often do you check your blood sugars?

□ I do not frequently check glucose □ I check daily,_____ times per day:
□ before breakfast □ after breakfast □ before lunch □ after lunch □ before dinner
□ after dinner □ overnight

9. How often do you have blood sugars under 70?

10. Do you currently have any of these symptoms?

□ frequent urination □ confusion/metal fog □ weight loss □ excess hunger
□ blurry vision
□ dizziness □ passing out □ numbness in feet
□ pain in feet □ ulcer(s) on foot

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11. Do you have any of the following health conditions?

□ Hypertension	□ Heart failure	□ COPD/emphysema	□ Lupus
□ Bariatric surgery	□ High cholesterol	□ Atrial fibrillation	
□ Rheumatoid arthritis	□ Cancer _____.	□ Pancreatitis	
□ Sleep apnea	□ Coronary artery disease	□ Ulcerative colitis/Crohns	□ Liver disease
□ Pancreas surgery			

□ Hypothyroidism	□ Adrenal insufficiency	□ Low testosterone	□ Pituitary tumor
□ Hyperthyroidism	□ Adrenal nodule	□ PCOS	□ Osteoporosis
□ Thyroid Nodule	□ Hyperparathyroidism	□ Abnormal periods	□ Kidney stones
□ Thyroid Cancer	□ High calcium	□ Infertility	□ Low vitamin D

□ Chronic fatigue	□ Depression	□ Anxiety Disorder
□ Fibromyalgia	□ Anemia	

□ Other health conditions not already mentioned (please write in space below):

12. Have you ever had any of the following diabetes complications?

□ Cataracts	□ Diabetes eye disease	□ Retinopathy	□ Retinal bleed
□ Eye surgery	□ Laser treatment		
□ Heart attack	□ Heart stents: how many _____	□ Bypass surgery	
□ Stroke/TIA	□ Carotid stent	□ Other stents	
□ Amputation	□ Foot ulcer	□ Foot infection	□ Charcot foot
□ Neuropathy			
□ Protein in the urine	□ Kidney disease	□ Kidney failure	□ Dialysis
□ Ketoacidosis	□ Hospitalized for high sugars	□ Pass out from low sugars	

13. Which statement(s) describe your approach to food?

□ I eat whatever I want	□ I eat until I am full	□ I limit sugar and sweets
□ I count carbohydrates and set carb limits		
□ I limit fried foods	□ I limit starchy foods	□ I eat whatever is available
□ I eat out frequently		

14. Have you worked with a diabetes educator?

□ I have completed a diabetes education class in the past 2 years
□ I have worked one on one with a diabetes educator (outside of the hospital)

15. What do you do for exercise? (What activity, how long, and how often)

16. What other doctors/providers do you see? (Please write their names in if you know)

□ Primary care doctor:	Last visit with primary care doctor (month/year)
□ Kidney doctor:	Last visit with kidney doctor (month/year)
□ Heart doctor:	Last visit with heart doctor (month/year)
□ Foot doctor:	Last visit with foot doctor (month/year)
□ Eye doctor:	Last visit with eye doctor (month/year)

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17. Have you had any surgeries (please list month and year if you remember)?

18. What other medications do you take? (please write in below, or bring a list of your medications to your appointment)

19. Do you have any medication allergies?

□ No known drug allergies □ I am allergic to (please list):

20. Menstrual History (women only)

Age at start of periods_____.
First day of last menstrual period_____ Are periods regular? □ Yes □ No
Number of day in cycle_____.
Total number of pregnancies_____ Number of Live births___Miscarriages____Abortions_____.
Are you menopausal? □ Yes □ No (If yes, what age):_____.
Have you had a hysterectomy? □ Yes □ No Have you had an oopherectomy? □ No □ one ovary removed □ both ovaries removed

21. Do you have any other symptoms?

□ Unexplained weight gain	□ Shortness of breath	□ Dark stool	□ Bruising easier
□ Cold intolerance	□ Chronic cough	□ Blood in stool	□ Bleeding easier
□ Heat intolerance	□ Coughing blood	□ Painful/difficult urination	□ Muscle weakness
□ Eye pain	□ Chest pain	□ Blood in urine	□ Hand tremor
□ Light sensitivity	□ Palpitations (heart racing)	□ Decreased sex drive	□ Seizures
□ Gritty sensation in the eye	□ Swelling in your ankles	□ Hair loss	□ Increased anxiety
□ Headaches	□ Trouble breathing lying down	□ Itchy skin	□ Trouble falling asleep
□ Change in hearing		□ Rash	□ Trouble staying asleep
□ Snoring	□ Heartburn	□ Dry Skin	□ Wake up tired most days
□ Neck Pain	□ Nausea	□ Excess hair growth	
□ Hoarseness	□ Vomiting	□ Hot flashes	
□ Difficulty swallowing	□ Diarrhea	□ Change in ring or shoe size	
□ Breast discharge	□ Constipation	□ Purple stretch marks	

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22. What health conditions run in the family? ***If you have multiple brothers/sisters, please indicate how many have the condition (eg: if you have 3 brothers and only one had diabetes, then write 1/3)***

	Mother	Father	Sister	Brother	MGM	MGF	PGM	PGF	Mat. Aunt	Mat. Uncle	Pat. Aunt	Pat. Uncle
Diabetes	□	□	□	□	□	□	□	□	□	□	□	□
High Calcium	□	□	□	□	□	□	□	□	□	□	□	□
Kidney stone	□	□	□	□	□	□	□	□	□	□	□	□
Osteoporosis	□	□	□	□	□	□	□	□	□	□	□	□
Kidney disease	□	□	□	□	□	□	□	□	□	□	□	□
Hypothyroid	□	□	□	□	□	□	□	□	□	□	□	□
Hyperthyroid	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid cancer	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid Nodule	□	□	□	□	□	□	□	□	□	□	□	□
Heart attack	□	□	□	□	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□	□	□	□	□
Pituitary tumor	□	□	□	□	□	□	□	□	□	□	□	□
Colon cancer	□	□	□	□	□	□	□	□	□	□	□	□
Breast cancer	□	□	□	□	□	□	□	□	□	□	□	□
Ovarian cancer	□	□	□	□	□	□	□	□	□	□	□	□
Leukemia	□	□	□	□	□	□	□	□	□	□	□	□
Lymphoma	□	□	□	□	□	□	□	□	□	□	□	□
Blood clots	□	□	□	□	□	□	□	□	□	□	□	□

23. Social History

A. Alcohol use (1 drink = 5 oz wine, 12 oz beer, 1.5 oz spirit) □ Never □ less than 7 drinks/week □ 7 – 14 drinks/week □ over 14 drinks/week

B. Do you smoke? □ Never □ Former □ Current If yes, how many cigarettes per day? _____

C. Do you use recreational drugs? □ Never □ Former □ Current If yes, which drugs?

D. How many children do you have? □ None □ One □ two □ three □ four □ other _____

E. Highest level of education? □ Did not complete highschool □ highschool □ some college □ 2yr college □ 4yr college □ post-graduate

F. Occupation and employer:

Thank you for taking the time to complete this history form