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Diabetes Control Center

New Patient Information Form

Name_____

1. MEDICATIONS:

Name of Medicine	Dose	Name of Medicine	Dose
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____
_____	____	_____	____

Medication Allergies:

Name of Medicine	Reaction	Name of Medicine	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Do you have diabetes?

- ☐ No – (if no skip to section 3)
- ☐ Yes
  - ☐ Type 2 ☐ Type 1 ☐ Other ☐ Don't know

About when was diabetes diagnosed?

- ☐ Less than 1 year ☐ 1 – 3 years ☐ 3 – 5 years ☐ 5 – 10 years
- ☐ 10 -20 years ☐ Over 20 years
- ☐ Eye examination in past 12 mo. ☐ Foot examination in past 12 mo.

Known problems from Diabetes

- ☐ None Known
- ☐ Retinopathy (blood vessel problems in back of eye)
- ☐ Nephropathy (reduced kidney function from diabetes)
- ☐ Protein in urine
- ☐ Neuropathy (nerve pain from diabetes)
- ☐ Peripheral Artery Disease (damaged leg arteries)
- ☐ Frequent Low Sugar (too low)

3. Do you have thyroid problems?

- ☐ No (if No skip to section 4)
- ☐ Yes
  - ☐ Underactive Thyroid ☐ Overactive Thyroid
  - ☐ Don't know if under or overactive
  - ☐ Goiter
  - ☐ Inflammation, pain or soreness of thyroid
  - ☐ Thyroid nodules
  - ☐ Biopsy or ☐ Surgery of thyroid
- ☐ Do you take Medicine for your thyroid function
  - ☐ No ☐ Yes
    - ☐ Do you take it on an empty stomach?
      - ☐ Yes ☐ No
    - ☐ Do you miss taking your medicine?
      - ☐ Yes ☐ No

4. Past Medical History

PLEASE CHECK ONLY POSITIVE ANSWERS

- ☐ Hospitalization in the past 6 months
- ☐ Asthma
- ☐ Prostate enlargement problems
- ☐ Depression ☐ Heart attack
- ☐ High blood fats (Cholesterol, triglycerides, LDL)
- ☐ Hypertension (high blood pressure)
- ☐ Kidney disease ☐ Liver disease
- ☐ Lung disease ☐ Pancreatitis
- ☐ Sleep apnea
- ☐ Others_____
- ☐ Cancer
  - ☐ *Breast* ☐ *Colon* ☐ *Prostate*
  - ☐ *Other*_____

5. Past Surgical History

Please Check if you have had

- ☐ No surgery (If no go to section 6)
- ☐ Amputation ☐ Appendectomy

☐ Breast surgery ☐ Heart stent placement
☐ Open heart surgery (bypass)
☐ Cataract surgery ☐ Cesarean section
☐ Gall bladder surgery
☐ Hernia repair ☐ Hip surgery
☐ Knee replacement ☐ Knee scope surgery
☐ Hysterectomy (partial or complete)
☐ Tonsillectomy
☐ Other _____

6. Family History

	Mother	Father	Brother	Sister
☐ Diabetes	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐
☐ Heart Attack	☐	☐	☐	☐
☐ Hypertension	☐	☐	☐	☐
☐ Kidney failure	☐	☐	☐	☐
☐ Cancer	☐	☐	☐	☐

7. Social History

☐ Tobacco use
- ☐ Never smoked ☐ Smoked in past Years smoked _____
- ☐ Currently smoke daily ☐ Currently smoke some days
- ☐ Use smokeless tobacco

☐ Alcohol
- ☐ Never used
- ☐ Used in past ☐ Current social use ☐ Current daily use

Review of Systems

	General		Stomach
☐	Frequent Headaches	☐	Trouble swallowing
☐	Weakness/Lethargy	☐	Heartburn/indigestion
☐	Night Sweats/Chills	☐	Change in bowel habits
☐	Fever	☐	Loose stools/Diarrhea
☐	Fainting Spells	☐	Constipation
☐	Weight Loss	☐	Frequent Stomach Pain
☐	Dizziness	☐	Colonoscopy Year_____
	Eyes/Ears/Nose/Throat		**Heart/Lungs**
☐	Eye pain	☐	Pounding Heart
☐	Double Vision	☐	Short of breath walking 1 block
☐	Noise in ears	☐	Chest Pain
☐	Sore Throat	☐	Swelling legs and feet
☐	Hoarseness	☐	Atrial Fibrillation
	Kidney/Bladder/Prostate	☐	Chronic Cough
☐	Frequent Urination	☐	Wheezing
☐	Burning on Urination		**Glands**
☐	Trouble Starting Urination	☐	Weight Loss
	Neurological	☐	Cold or Heat intolerance (circle)
☐	Severe Weakness	☐	Increased Sweating
☐	Paralysis	☐	Difficult Swallowing
	Joints	☐	Hair loss
☐	Joint Swelling	☐	Excessive Dry Skin
☐	Morning Stiffness	☐	Heavy or Changed Menstruation
☐	Chronic Joint Pain	☐	Tremor