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Diabetes New Patient Form

Date: _____
Name: _____ Age: _____ Sex: _____
Date of Birth: _____
Address: _____
City_____, State_____, Zip_____
TEL: (Home): _____ Cell: _____
Ethnicity: ____White ____Black ____Hispanic ____Asian ____other
Referred by: _____ Ref. Dr. Tel: _____
Primary Care Physician: _____Tel: _____
Reason for visit: _____

History of Present Illness:

What type of Diabetes do you have? ____Type 1 ____Type 2
Age at Diagnosis: _____ When and How diagnosed: _____
Last Hemoglobin A1C Blood test (3 month glucose average): _____
How many times a day you test: _____ Do you have episodes of
Hypoglycemia (Low Blood Sugar): _____
If so, how often? _____

Glucose Levels at home:

Fasting / Before Breakfast:	
Post Breakfast:	
Before Lunch:	
After Lunch:	
Before Dinner:	
After Dinner:	
Bedtime:	

Are you on Insulin? ☐ Yes ☐ No

Type of Insulin	AM Dose	Mid-day Dose	PM Dose	Bedtime Dose

Are you on an Insulin Pump? ☐ Yes ☐ No
Pump Type (Brand)? _____
Insulin Used in Pump? _____

Pre-meal or pump bolus:

AM Dose	Mid-day Dose	PM Dose
_____**Units**	_____**Units**	_____**Units**
_____**Carbs**	_____**Carbs**	_____**Carbs**

Pump Basal Rates: _____

_____

Insulin Sensitivity: _____

Factor: _____

Insulin to Carb Ratio: _____

When was your last visit with Eye Doctor: **Date**_____ Retinopathy? Yes/ No _____

Dentist: Date: _____

Any recent infections? ☐ Yes ☐ No If so, what kind? _____

When? _____

Dietetic History:

Last Visit with a Dietician or Diabetes Educator: _____

Do you follow a diet? _____ Do you eat fast food? _____

Do you skip meals? _____ How many meals a day do you eat? _____

Do you exercise? _____ If so, how often? _____

Past Medical History

High Blood Pressure):	☐ Yes	☐ No	
Stroke:	☐ Yes	☐ No	
Heart Disease:	☐ Yes	☐ No	
High Cholesterol:	☐ Yes	☐ No	
Liver Disease/Hepatitis:	☐ Yes	☐ No	
Osteoporosis:	☐ Yes	☐ No	
GI Disease:	☐ Yes	☐ No	
Cancer:	☐ Yes	☐ No	If so, what type? _____
Depression:	☐ Yes	☐ No	
Eating Disorders:	☐ Yes	☐ No	

Other history**:** _____

Family Medical History:

Diabetes	
Thyroid Disorder	
High Blood Pressure	
Heart Disease	
High Cholesterol	
Osteoporosis	
Cancer / what kind	
Obesity	
Other Endocrine Disorder	

GM = grandmother M = mother S = sibling GF = grandfather F = father

Past Surgery: _____

_____

_____

Gynecological/OB History: Age of first menstrual period: _____
Cycles Regular: _____
Any OB/GYN Surgeries: _____
Prior Pregnancies: _____How Many were live births? _____
Are you on hormone therapy: _____
Any History of PCOS (polycystic ovarian syndrome)? _____
Have you ever had Gestational Diabetes? _____

Social History

□Married □Single □Divorced □Separated □Widowed
Occupation:_____
Do You Smoke? □ Yes □ No Current Smoker or Ex-Smoker?_____
If so how much?_____ How long:_____
Do you drink Coffee? □ Yes □ No Cups per Day?_____
Do you use Alcohol? □ Yes □ No How Often?_____
Do you use Drugs? □ Yes □ No

Immunizations
Pneumonia Vaccine: (Date)_____
Tetanus Vaccine: (Date)_____
Flu Vaccine: (Date)_____

Current Medications: Please include Over the Counter Meds and Vitamins

Name	Dosage	Instructions

Pharmacy Name:_____
Pharmacy Number:_____
Drug Allergies:_____

REVIEW OF SYSTEMS:

Name: **Date:**

(Please circle all that apply)

CONSTITUTIONAL: weakness, fatigue, weight loss, weight gain, fever, chills, sweats, insomnia, snoring
HEAD: headache
EYES: visual changes, defects, blurring of vision
NOSE: nose bleeds, discharge
MOUTH & THROAT: dental disease, hoarseness, sore throat, pain, trouble swallowing
PULMONARY: cough, night sweats, wheezing, shortness of breath on exertion or on sleeping flat, pain with inspiration
CARDIOVASCULAR: chest pain, heart racing, sudden collapse or loss of consciousness, shortness of breath, swelling of feet, cramps in calves or thighs with walking, irregular heart rate
GASTROINTESTINAL: nausea, vomiting, diarrhea, constipation, changes in bowel habits, abdominal pain, black stools or blood in stools, yellowness of eyes, appetite changes, early feeling of fullness on eating
MUSCULOSKELETAL: back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, arthritis
SKIN: rash, itching, dryness, changing mole size or other suspicious lesions
NEUROLOGICAL: weakness, tingling or numbness, seizures, tremors, memory problems or gait problems
HEMATOLOGIC: easy bruising, bleeding, joint swelling
PSYCHIATRIC: depression, anxiety, memory loss

ENDOCRINE REVIEW OF SYSTEMS ***(Please circle all that apply)***

PITUITARY/HYPOTHALAMUS: headaches, visual defects, increased thirst or urination, milky discharge from breast, painful breast swelling, increased head/hand or shoe size, history of pituitary tumor, peptic ulcer disease, family history of kidney stones, family history of multiple endocrine tumors
THYROID: fatigue, anxiety, nervousness, tremor, heat intolerance, cold intolerance, lethargic, dry skin, constipation, heart racing, weight loss, weight gain, sweating, hair loss, neck pain, history of head or neck radiation, difficulty swallowing or breathing, family history of thyroid cancer
PARATHYROID: increased thirst and urination, history of kidney stones, use of antacids, calcium supplements, bone pain, muscle aches, loss of height, history of fractures
ADRENAL: darkening of skin/gums, salt craving, skin stretch marks, easy bruising, diarrhea, vomiting, weight loss, change in facial or physical appearance, excess hair growth over face/chin/chest/or abdomen, weight gain, difficulty raising arms overhead, difficulty getting up from a seated position
GENITOURINARY: irregular menstrual cycles, hot flashes, impotence, decreased libido, erectile dysfunction, decreased hair growth
BONE: height loss over the years, history of fracture, family history of osteoporosis

Symptoms reviewed today:

Vidhya Subramanian, MD Date:

For Doctors Use Only

PHYSICAL EXAMINATION

Height_____ Weight_____ BMI _____ Blood Pressure_____
Pulse_____ Blood Sugar_____ (Random / Fasting)

PHYSICAL EXAM:

- GEN: Alert, oriented, in no acute distress
- Head: Atraumatic, normocephalic
- EYES: Pupils equally reactive to light, EOM normal, No stare, lid lag or proptosis
- ENT: No exudates, redness of pharynx, no ear discharge, nasal, dentition
- NECK: Thyroid:
- CVS: Heart sounds regular, no gallop or murmur
- RS: Equal breath sounds, no crackles, no wheezes
- ABDOMEN: Soft, non-tender, liver/spleen not palpable, no wide, red striae
- EXTREM: No clubbing, cyanosis, edema
- PULSES: peripheral: PT / DP
- FEET: No blisters, callus. Sensations to monofilament normal/diminished

  Right foot: Left foot:
- SKIN: breakdown, ulcers, sores, acanthosis, hirsutism, vitiligo
- NEURO: Alert, oriented x3, No tremors, No gross focal motor deficit, DTRs normal
- GENITAL:
- OTHER:

LABS: _____
_____
_____

RADIOLOGY:
_____
_____
_____

ASSESSMENT & PLAN: _____
_____
_____

REFERRALS: _____ **FOLLOW UP**: _____

Vidhya Subramanian, MD