LAUREL ENDOCRINE & Thyroid Specialists, PA

1740 St. Julian Place, Columbia, SC 29204
Phone: 803-256-3534 Fax: 803-254-7032

Diabetes History

Date_____ Patient Name _____

Date of Birth _____

Age of diagnosis: _____ When did you start insulin?_____

What is your biggest concern related to your diabetes?

		YES	NO
Complications related to DM	Low blood sugars	___	___
	Diabetic ketoacidosis	___	___
	Numbness/tingling	___	___
	Eye damage	___	___
	Kidney damage	___	___
	Nonhealing wound	___	___

How many times per day do you check your sugar level? _____

How many times per week do you exercise? _____

What type of exercise do you like?_____

When was your last diabetes education? _____

Do you have someone in your home that can help you case you have a low blood sugar? _____

Current diabetes medications:

_____
_____
_____
_____
_____

Past diabetes medications and why they were stopped:

_____
_____
_____
_____
_____

Cardiologist: _____ Last appointment: _____

Podiatrist: _____ Last appointment: _____

Nephrologist:_____ Last appointment: _____

Ophthalmologist:_____ Last appointment: _____

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Past Medical History

Date_____ Patient Name _____

	YES	NO
High blood pressure	_____	_____
Diabetes	_____	_____
High cholesterol	_____	_____
Heart attack or stroke	_____	_____
Congestive heart failure	_____	_____
Sleep apnea	_____	_____
Heart disease	_____	_____
Seizures	_____	_____
Kidney disease	_____	_____
Gall stones	_____	_____
Kidney stones	_____	_____
Pancreatitis	_____	_____
Peptic ulcer disease	_____	_____
Thyroid disease	_____	_____
Thyroid cancer	_____	_____
Prostate cancer	_____	_____
Other cancers	_____	_____
Low testosterone	_____	_____
Chronic steroid use	_____	_____
COPD/asthma	_____	_____
Anemia	_____	_____
Menopause	_____	_____
Psychiatric illness	_____	_____
Joint replacements	_____	_____
Osteoporosis	_____	_____
Bone fractures	_____	_____
Rheumatologic disease	_____	_____

Other medical conditions not listed:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Prior Surgeries:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Medications

Do you have any drug allergies? Yes / No
If so, please list them _____ _____
_____ _____

_____
_____
_____
_____
_____
_____
_____
_____

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Past Medical History

Date_____ Patient Name _____

	YES	NO	If yes, how much?
Do you smoke?	_____	_____	_____
Do you drink?	_____	_____	_____
Do you use recreational drugs?	_____	_____	_____

What is your occupation? _____

Married / Widow (er) / single / divorced

Family History

Has anyone in your immediate family (only parents, siblings, children) had:

	YES	NO
High blood pressure	_____	_____
Diabetes	_____	_____
High cholesterol	_____	_____
Heart attack or stroke	_____	_____
Heart failure	_____	_____
Prostate cancer	_____	_____
Calcium disorders	_____	_____
Thyroid cancer	_____	_____
Psychiatric illness	_____	_____
Other thyroid disease	_____	_____
Pituitary problems	_____	_____
Kidney disease	_____	_____

Other medical conditions not listed:

_____
_____
_____
_____
_____
_____
_____
_____
_____

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Date _____ Patient Name _____

Review of Systems

Circle any symptoms you have:

General
- Fever / chills
- Weight loss
- Weight gain
- Night sweats
- Weakness / fatigue

Endocrine
- Cold intolerance
- Heat intolerance
- Excessive thirst
- Excessive urination
- Excessive sweating
- Flushing
- Tremulousness
- Changes in body hair

Skin
- Rash/purple or red spots/pigment
- Fingers/toes turn colors in the cold
- Nail problems
- Dry skin
- Skin ulcers

Neurologic
- Migraines
- Headaches
- Numbness/tingling
- Muscle Weakness
- Seizures
- Muscle Cramps
- Difficulty thinking or remembering

Scalp/Head
- Hair loss
- Scalp tenderness
- Headache

Eyes
- Blurry vision
- Double vision
- Decreased peripheral vision
- Eye pain
- Dry eyes

Ears/Nose/Throat
- Noticeable swelling in neck
- Hearing loss
- Ear pain
- Ringing in ears
- Vertigo
- Nasal congestion
- Loss of sense of smell
- Hoarse voice

Musculoskeletal
- Painful joints
- Muscle pain
- Back pain

Mouth
- Sores in mouth
- Dry mouth
- Dental problems
- Loss of taste
- Difficulty swallowing

Allergy
- Frequent sneezing
- Seasonal allergies

Respiratory
- Shortness of breath
- Cough
- Wheezing
- Chest pain with breathing

Blood/Lymph
- Easy bruising
- Enlarged lymph nodes

Gastrointestinal
- Nausea/vomiting
- Constipation/diarrhea
- Hemorrhoids
- Change in appetite

Genitourinary
- Irregular menses
- Hot flashes
- Blood in urine
- Decreased urine stream
- Prostrate problems
- Frequent urinary tract infections
- Decreased sexual desire

Heart
- Chest pain
- Stabbing chest pain/pericarditis
- Irregular or rapid heart rate
- Lightheadedness/Passing out
- Sleep on more than 2 pillows due to shortness of breath
- Leg swelling

Psychological
- Anxiety
- Depression
- Difficulty sleeping
- High stress

Breasts
- Lumps
- Pain
- Discharge

Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____