

Diabetes History

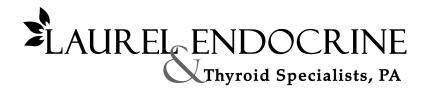
Date Patient N	Jame
Date of Birth	
Age of diagnosis:	When did you start insulin?
What is your biggest concern relat	ed to your diabetes?
Complications related to DM	YES NO Low blood sugars Diabetic ketoacidosis Numbness/tingling Eye damage Kidney damage Nonhealing wound YES NO MES NO Mumbness/tingling Eye damage Kidney damage Nonhealing wound
How many times per day do you c	heck your sugar level?
How many times per week do you	exercise?
What type of exercise do you like	?
When was your last diabetes education	ation?
Do you have someone in your hon	ne that can help you case you have a low blood sugar?
Current diabetes medications:	
Cardiologist:Podiatrist:	Last appointment:
Nephrologist:	Last appointment:
Ophthalmologist:	Last appointment:



Date	Patient Naı	me	
	YES	NO	Other medical conditions not listed:
High blood pressure			
Diabetes			
ligh cholesterol			
leart attack or stroke			
Congestive heart failure			
leep apnea			
leart disease			
eizures			
Lidney disease			
all stones			
Lidney stones			
ancreatitis			
eptic ulcer disease			
hyroid disease			
hyroid cancer			Prior Surgeries:
rostate cancer			Č
other cancers			
ow testosterone			
hronic steroid use			
OPD/asthma			
nemia			
lenopause			
sychiatric illness			
oint replacements			
steoporosis			
Sone fractures			
heumatologic disease			
]	Medications
Oo you have any drug f so, please list them	allergies? Y	es / No	
, F			



		Pas	st Medical History
DatePa	ntient Nam	e	
Do you smoke? Do you drink?	YES	NO	If yes, how much?
Do you use recreational drugs?			
What is your occupation?			
Married / Widow (er) / single / d	livorced		
. , ,			
			Family History
Has anyone in your immedi	ate family		
	YES	NO	Other medical conditions not listed:
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		_	



Date Patient Nar	me	
	Review of Systems	
Circle any symptoms you have:		
General Fever / chills Weight loss Weight gain Night sweats Weakness / fatigue	Eyes Blurry vision Double vision Decreased peripheral vision Eye pain Dry eyes	Blood/Lymph Easy bruising Enlarged lymph nodes Gastrointestinal Nausea/vomiting Constipation/diarrhea
Endocrine Cold intolerance Heat intolerance Excessive thirst Excessive urination Excessive sweating Flushing Tremulousness Changes in body hair	Ears/Nose/Throat Noticeable swelling in neck Hearing loss Ear pain Ringing in ears Vertigo Nasal congestion Loss of sense of smell Hoarse voice	Hemorrhoids Change in appetite Genitourinary Irregular menses Hot flashes Blood in urine Decreased urine stream Prostrate problems Frequent urinary tract infections
Skin Rash/purple or red spots/pigment Fingers/toes turn colors in the cold Nail problems Dry skin Skin ulcers Neurologic	ld Muscle pain Back pain Mouth Sores in mouth Dry mouth	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
Migraines Headaches Numbness/tingling Muscle Weakness Seizures Muscle Cramps Difficulty thinking or remembering Scalp/Head Hair loss Scalp tenderness Headache	Dental problems Loss of taste Difficulty swallowing Allergy Frequent sneezing Seasonal allergies Respiratory Shortness of breath Cough Wheezing Chest pain with breathing	Psychological Anxiety Depression Difficulty sleeping High stress Breasts Lumps Pain Discharge

Signature

I certify that my answers are true and complete to t	the best of my knowledge.	
Signature:	Date:	