Lawrence Endocrinology

Affiliated with Lawrence Memorial Hospital

Patient Name _____ **Date of birth** _____

New Patient-Diabetes Form

1. How old were you (approximately) when you were diagnosed with diabetes?
2. Have you used any other diabetes medications in the past? If yes, please list the names.

   _____ _____

   _____ _____

   _____ _____
3. How many times a day do you check your blood sugar?
   a. 1-2 times per day
   b. 3-4 times per day
   c. 5-6 times per day
   d. Rarely/Never
4. On average, in what range does your blood sugar run:
   a. Fasting in the morning prior to breakfast _____
   b. Prior to lunch _____
   c. Prior to dinner _____
   d. At bedtime _____
5. On average, how many times a week do you have low blood sugar (less than 70mg/dL)?
   a. 1-2 times per week
   b. 3-4 times per week
   c. More than 4 times per week
   d. Rarely/Never
6. Any particular time of the day when you are more likely to get low blood sugar?

   _____
7. Do you feel "low blood sugar" symptoms when your blood sugar gets low? Yes No
8. In the past year have you required someone else's help in treating a low blood sugar episode? Yes No
9. Have you ever passed out with low blood sugar? Yes No
10. Do you count amount of carbohydrates in your meals? Yes No
11. How many meals a day do you eat?
12. How often do you forget to take your diabetes mediations?
    a. Never
    b. Rarely
    c. Once a week
    d. 2-3 times/week or more

Complications from Diabetes

1. Do you have any of the following in your feet?
    a. Numbness Yes No
    b. Tingling Yes No
    c. Burning sensation in Yes No
2. Do you have any loss of sensation in your feet? Yes No
3. When was your last eye exam? Date: _____
4. Did your eye doctor mention about any about any diabetic changes at the back of your eyes? Yes No
5. Have you ever required laser treatment at the back of your eyes? Yes No
6. When was your last dental exam? Date: _____
7. Do you get lightheaded of dizzy upon standing up from a sitting or laying down position? Yes No
8. Do you get nausea/bloating/abdominal fullness just after eating a meal? Yes No

Family History

1. Any family history of diabetes? If yes, who had it and what of diabetes (type 1 or type 2 or unknown) _____
   _____
2. Any history of type 2 diabetes at an early age? Yes No
3. Any family history of high blood pressure? Yes No
4. Any family history of high cholesterol? Yes No
5. Any family history of heart attack or stroke? Yes No

Social History

1. Do you work? Yes No What kind of work do you do? _____
2. Do you smoke? Yes No How many packs per day? _____
3. Do you drink alcohol? Yes No If yes, how often/how much? _____
4. Do you exercise? Yes No
   If yes, how often?_____ How long? _____ What kind of exercise? _____

Immunizations

1. When was your last flu shot? _____
2. Have you received the pneumonia vaccine (pneumovax)? Yes No If yes, when? _____