Name: _____ **MR#:** _____**Date:**_____ **Pg. 1 of 3**

Filling out this form allows us to focus on special issues if needed during your office visit. Thanks!

1. Have there been any Hospitalization, Surgery, Fracture or Major Illness since the last visit? ○ Yes ○ No
2. Have there been any **NEW** School, Family, or Social Problems since the last visit? ○ Yes ○ No
3. Any Family members with new onset of diabetes, heart attack, stroke, cancer, thyroid disease, osteoporosis, pituitary or other hormone related problems since your last visit? ○ Yes ○ No
4. You usually check your blood sugar level: ○ Rarely ○ Once daily ○ Twice daily ○ Three times daily ○ >3 Times daily
5. Did you bring your meter or record of glucose readings to visit? ○ Yes ○ No
6. Breakfast Blood Sugar Level: ○ 80-120 ○ 120-140 ○ 140-160 ○ 160-180 ○ 180-200 ○ 200-240 ○ >240
7. Lunch Blood Sugar Level: ○ 80-120 ○ 120-140 ○ 140-160 ○ 160-180 ○ 180-200 ○ 200-240 ○ >240
8. Supper Blood Sugar Level ○ 80-120 ○ 120-140 ○ 140-160 ○ 160-180 ○ 180-200 ○ 200-240 ○ >240
9. Bedtime Blood Sugar Lev ○ 80-120 ○ 120-140 ○ 140-160 ○ 160-180 ○ 180-200 ○ 200-240 ○ >240
10. My overall Blood glucose readings average: ○ 80-120 ○ 120-140 ○ 140-160 ○ 160-180 ○ 180-200 ○ 200-240 ○ >240
11. Most Frequent time of Low Blood Sugar: ○ Morning ○ Mid-Morning ○ Noon ○ Mid-Afternoon ○ Evening ○ Bedtime ○ Middle of Night
12. My meal or snack plan is: ○ None ○ ADA ○ Weight Watchers ○ Low Carbohydrates ○ Carb counting ○ Low Fat ○ Other:_____
13. Do you skip meals? ○ Yes ○ No
14. My exercise plan is mostly: ○ Walking ○ Running ○ Swimming ○ Lifts Weights
15. Frequency of exercise per week? ○ 1-2 times ○ 2-3 times ○ 3-4 times ○ >4 times
16. Have you seen an eye doctor in the last year? ○ Yes ○ No
17. Have you seen dietitian in the last year? ○ Yes ○ No
18. Do you smoke? ○ Yes ○ No
19. If you smoke, would you like to quit? ○ Yes ○ No
20. Do you wear a medic alert bracelet or necklace? ○ Yes ○ No
21. Do you have a Glucagon kit at home? ○ Yes ○ No
22. Do your carry and have in car sugar raising "stuff"? ○ Yes ○ No

Have there been any chronic problems **(lasting more than two weeks)** that have **developed since the last visit?** (Please mark NONE per category if nothing applies)

General ○ **NONE**

Weight loss:	○ Yes	○ No
Excessive weight gain	○ Yes	○ No
Decreased appetite:	○ Yes	○ No
Increased appetite:	○ Yes	○ No
Fatigue:	○ Yes	○ No
Fever:	○ Yes	○ No
Excessive sweating:	○ Yes	○ No
Dizziness:	○ Yes	○ No

Gastrointestinal ○ **NONE**

Nausea:	○ Yes	○ No
Vomiting:	○ Yes	○ No
Abdominal pain:	○ Yes	○ No
Fullness or bloating:	○ Yes	○ No
Heartburn:	○ Yes	○ No
Blood in stool or black stool:	○ Yes	○ No
Constipation:	○ Yes	○ No
Diarrhea:	○ Yes	○ No

Endocrine ○ **NONE**

Heat Intolerance:	○ Yes	○ No
Cold Intolerance:	○ Yes	○ No
Breast changes:	○ Yes	○ No
Extreme Thirst:	○ Yes	○ No
Low Blood Sugar:	○ Yes	○ No
Increased ring and/or shoe size:	○ Yes	○ No

Eyes ○ **NONE**

Blurred Vision:	○ Yes	○ No
Bleeding in eyes or glaucoma:	○ Yes	○ No
Bulging of eyes:	○ Yes	○ No
Dryness of eyes:	○ Yes	○ No
Eye Pain:	○ Yes	○ No

HENT/Neck ○ **NONE**

Nose Bleeds:	○ Yes	○ No
Sore Throat:	○ Yes	○ No
Chronic headaches:	○ Yes	○ No
Neck Pain:	○ Yes	○ No
Difficulty swallowing:	○ Yes	○ No
Change in voice:	○ Yes	○ No
Swollen lymph nodes:	○ Yes	○ No

Cardiovascular ○ **NONE**

Chest pain:	○ Yes	○ No
Racing heart rate:	○ Yes	○ No
Slow heart rate:	○ Yes	○ No
Palpitations/pounding heart:	○ Yes	○ No
Swollen legs:	○ Yes	○ No
Abnormal heart rhythm:	○ Yes	○ No
Tightness/pressure in chest:	○ Yes	○ No
Shortness of breath with activity:	○ Yes	○ No
Leg Pain with walking:	○ Yes	○ No

Respiratory ○ **NONE**

Shortness of breath:	○ Yes	○ No
Difficulty breathing:	○ Yes	○ No
Chronic cough:	○ Yes	○ No
Wheezing:	○ Yes	○ No

Skin ○ **NONE**

Nail changes:	○ Yes	○ No
Rashes:	○ Yes	○ No
Color changes:	○ Yes	○ No
Changes in elbow/neck area:	○ Yes	○ No
Acne changes:	○ Yes	○ No
Excessive hair growth:	○ Yes	○ No
Excessive hair loss:	○ Yes	○ No
Itching/dryness:	○ Yes	○ No
Easy bruising:	○ Yes	○ No
Prolonged bleeding:	○ Yes	○ No
New stretch marks:	○ Yes	○ No
Skin “tags”:	○ Yes	○ No

Musculoskeletal ○ **NONE**

Joint pain:	○ Yes	○ No
Swelling/stiffness of joints:	○ Yes	○ No
Muscle cramps:	○ Yes	○ No
Back pain:	○ Yes	○ No
Weakness:	○ Yes	○ No
Recent change in height:	○ Yes	○ No
Fracture since the last visit:	○ Yes	○ No

Neurologic ○ **NONE**

Headaches:	○ Yes	○ No
Double vision:	○ Yes	○ No
Fainting spells:	○ Yes	○ No
Seizures:	○ Yes	○ No
Loss of sensation:	○ Yes	○ No
Trembling hands:	○ Yes	○ No
Confusion:	○ Yes	○ No
Slurred speech:	○ Yes	○ No
Tingling/numbness:	○ Yes	○ No
Pain in hands/feet:	○ Yes	○ No
Trouble walking:	○ Yes	○ No
Trouble with coordination:	○ Yes	○ No

Genitourinary ○ **NONE**

Blood in urine:	○ Yes	○ No
Incontinence:	○ Yes	○ No
Frequent urination:	○ Yes	○ No
Night time urination:	○ Yes	○ No
Weak urine stream:	○ Yes	○ No
Kidney stones:	○ Yes	○ No
Decreased kidney function:	○ Yes	○ No
Decreased sexual function:	○ Yes	○ No

Psychiatric ○ **NONE**

History of mental illness:	○ Yes	○ No
Anxiety or nervousness:	○ Yes	○ No
Depression:	○ Yes	○ No
Stress:	○ Yes	○ No
Insomnia:	○ Yes	○ No
Panic attacks:	○ Yes	○ No

Females ONLY - GYN ○ **NONE**

Irregular periods:	○ Yes	○ No
Lack of periods:	○ Yes	○ No
Breast discharge or fullness:	○ Yes	○ No
Painful intercourse:	○ Yes	○ No
Difficulty becoming pregnant:	○ Yes	○ No

Pediatrics ONLY ○ **NONE**

Decreased growth [height]:	○ Yes	○ No
Excessive growth [height]:	○ Yes	○ No
Delay in puberty:	○ Yes	○ No
More developed puberty:	○ Yes	○ No

Please list NEW medications or CHANGES to existing medications since last visit: (Include vitamins, herbs, aspirin, estrogens & contraceptives; if on an **insulin pump**: list basal rates, carbohydrate ratios and correction factors)

	MEDICATION	DOSE	HOW OFTEN?
1.			
2.			
3.			
4.			
5.			

What is the biggest area that you feel needs to be worked on or improved? _____

_____

PLEASE GIVE THIS SHEET TO THE FRONT DESK BEFORE YOU ARE CALLED BACK TO A ROOM. PLEASE LET THE NURSE KNOW IF YOU NEED YOUR PRESCRIPTIONS REFILLED. We suggest you keep a list of medications with doses and frequency in your wallet or purse. Thanks again very much!

☐ **Yes, I need prescriptions.** ☐ **No prescriptions needed at this visit**

If yes: ☐ **30 day supply with refills, or** ☐ **90 day supply with refills.**

My pharmacy is: _____. ☐ **no change in pharmacy.**