Type II Diabetes New Patient Application and Case History

Name ______________________________ Age ______ Sex: M F DOB ________ Today's Date __________

Address ______________________________ City______________________ State ________ Zip ________________

Home Phone ________________ Work Phone _________________ Cell Phone _________________ e-mail: ______________

May we leave a voice mail? Y N Height ______ Weight: ______ Marital Status: S/ M/ W/Sep./D Spouse ____________________

How Did You Hear About Us? ____

Employer _______________________ Occupation _________________ Length of Employment _____ SSN _____-____-_____

Present Complaints

1. Main Problem(s): ____

2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : ____

3. When were you diagnosed with Type II diabetes: ____________________
   What diagnostic tools were used to achieve your diagnosis:
   ____

4. Symptoms(list all):
   ____

5. What are the three things your condition has caused you to miss most:
   ____

6. Severity of problem (circle):
   Minimal (annoying but causing no limitation)
   Slight (tolerable but causing a little limitation)
   Moderate (sometimes tolerable but definitely causing limitation)
   Severe (causing significant limitation)
   Extreme (causing near constant limitation (>80% of the time))

7. What relieves your symptoms or causes them to return:
   ____

8. Describe the first time you remember having symptoms:
   ____

9. If your symptoms include pain:
   What is the quality (sharp, dull, stabbing, color, etc.): ______________
   Does the pain radiate: Y N where: ______________

10. Do your symptoms occur at a specific time, place, or environment: Y N
    When and for how long do symptoms last each episode:
    ____

11. What types of treatment have you received:
    Prescription/Drug therapy______________
    Nutritional ______________
    Alternative/Holistic ______________

12. List your health goals in order of Importance:
    ____
    Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

13. What are you hoping happens today as a result of your consultation:
    ____

14. How often are you aware of your main problem (circle one):
    Occasionally (25% of the time) Frequently (75% of the time)
    Intermittently (50% of the time) Constantly (100% of the time)

15. If you cannot find a solution to your problem what do you think will happen?

____

____

16. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?

Work: Y N Describe: ____

Family: Y N Describe: ____

Leisure Activities Y N Describe: ____

Blood Sugar

HIGHEST your blood sugar gets WITHOUT medication __________

LOWEST your blood sugar gets WITHOUT medication __________

HIGHEST your blood sugar gets WITH medication __________

LOWEST your blood sugar gets WITH medication __________

Medications

(List all prescription, over-the-counter, **botanicals, homeopathic, and supplements**)

____

____

____

Medical and Social History

Surgeries/Hospitalizations Date : _________

____

Past/Recent Illness Date : _________

____

Family History (mother, father, siblings, spouse, children) Date : _________

____

Trauma Date : _________

____

Children / ages:

____

Do you use: Alcohol Y N Tobacco Y N Caffeine Y N

_________ drinks/week __________ pack/day __________ cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL

P C Fatigue
P C Recent weight change
P C Fever

EYES

P C Blurred/double vision
P C Glasses/contacts
P C Eye disease or injury

EAR/NOSE/MOUTH/THROAT

P C Swollen glands in neck
P C Hearing loss or ringing
P C Earaches or drainage
P C Chronic sinus problems or rhinitis
P C Nose bleeds
P C Mouth sores / Bleeding gums
P C Bad breath / bad taste
P C Sore throat or voice change

CARDIOVASCULAR

P C High or Low Blood Pressure
P C Shortness of breath walking/lying
P C Heart disease
P C Chest pain or angina pectoris
P C Palpatation
P C Mitral Valve Prolapse
P C Feet or ankle swelling
P C Shortness of breath
P C Spitting up blood

PSYCHIATRIC

P C Insomnia
P C Memory loss or confusion
P C Nervousness
P C Depression

GENITOURINARY

P C Frequent urination
P C Burning or painful urination
P C Blood in urine
P C Change in force or strain urinating
P C Kidney stones
P C Sexual difficulty
P C Male : testicle pain
P C Female: pain / irregular periods
P C Female: pregnant
P C Bladder Infections
P C Kidney Disease
P C Hemorrhoids

GASTROINTESTINAL

P C Abdominal pain
P C Nausea or Vomiting
P C Rectal bleeding/blood in stool
P C Painful bm / constipation
P C Ulcer
P C Change in bowel movement
P C Frequent diarrhea
P C Loss of appetite

RESPIRATORY

P C Chronic or frequent cough
P C Spitting up blood
P C Pneumonia / Bronchitis
P C Shortness of breath
P C Wheezing
P C Asthma

ENDOCRINE

P C Glandular or hormone problem
P C Excessive thirst or urination
P C Heat or cold intolerance
P C Skin becoming dryer
P C Change in hat or glove size
P C Diabetes
P C Thyroid Disease

MUSCUOSKELETAL

P C Back pain
P C Joint pain
P C Joint stiffness and swelling
P C Muscle pain or cramps
P C Muscle or joint weakness
P C Difficulty walking
P C Cold extremities

INTEGUMENTARY (skin, breast)

P C Change in skin color
P C Change in Hair or Nails
P C Varicose veins
P C Breast pain / discharge
P C Breast lump
P C Hives or Eczema
P C Rash or itching

NEUROLOG ICAL

P C Freq./ recurring headaches
P C Migraine headache
P C Convulsions or seizures
P C Numbness or tingling
P C Tremors
P C Paralysis
P C Head injury
P C Light headed or dizzy
P C Stroke

HEMATOLOGIC/LYMPHATIC/OTHER

P C Slow to heal after cuts
P C Easy bleeding or bruising
P C Anemia
P C Phlebitis
P C Past transfusion
P C Enlarged glands
P C Blood or Plasma Transfusions
P C Hepatitis
P C Cancer
P C Infectious Mono
P C AIDS or HIV+
P C Venereal
P C Chicken pox

ALLERGIES / OTHER (drugs, food, or environmental) ____________________

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RECENT TESTS (lab work, x-rays, CT, MRI) ____________________

____

____

OTHER PROVIDERS

____

____

Doctor's Notes

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