New Patient Form

Demographic Data: **Today's Date:**_____

Patient Name: _____Preferred Name: _____Preferred pronoun:_____
First Last

Date of Birth:_____ Cell Phone: _____Email address:_____

Sex: ☐ M ☐ F ☐ Other Gender Assigned at Birth: ☐ M ☐ F

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian Other_____

Language Spoken at Home:_____

Is patient under age of 18? ☐ No ☐ Yes, Please complete box below:

Name(s) of Parent(s) or Legal Guardian (paperwork must be presented):

_____
First Last

Email address: _____Cell phone: _____

Home Phone:_____ Work Phone: _____Ext_____

Preferred Contact: Home Phone Cell __ Work phone Email US Mail

Address_____Apt_____City_____Zip_____

Primary MD: _____Name of office:_____

Referring MD: _____Name of office:_____

Reason for visit: *If Diabetes, please complete the Diabetes information below.

_____

_____

Diabetes Type: Type 1 ☐ Type 2 ☐ Gestational ☐ Other_____

Date Diagnosed: _____Hospitalized at Diagnosis? ☐ No ☐ Yes → in DKA? ☐ No ☐ Yes

Most recent Diabetes Education visit:_____

Details of Insulin Therapy

Insulin(s) currently using: ☐ Humalog ☐ Novolog ☐ Apidra ☐ U-500 ☐ Afrezza ☐ 50/50

☐ Lantus ☐ Levemir ☐ Toujeo ☐ Tresiba ☐ Basaglar ☐ NPH ☐ Regular ☐ 70/30

Mode of therapy: ☐ Inhaled ☐ Insulin/Vial Insulin/Pens

Pump, which one? _____ Start Date?_____

Testing Regimen: Meter:_____Tests/day:_____

Continuous Glucose Sensor_____

Date of last eye exam Date of last foot exam

Past Medical History:

Major events, hospitalizations, surgeries:_____

_____

Women: Pregnancies(#):____ Live births(#):____Miscarriages (#): ____

Are you pregnant? ☐ No ☐ Yes, Due Date_____

Men: Have you fathered children? ☐ No ☐ Yes

Allergy/Reaction: (example: Penicillin/Rash)_____

_____

Ongoing medical problems:_____

_____

_____

_____

Family History:

Relation	State of Health	Age at Death	Health Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Do any Blood Relatives have:

Type I Diabetes ☐ Type II Diabetes ☐ Thyroid condition ☐ Cancer ☐ Osteoporosis ☐

PCOS ☐ Pituitary problem ☐ Heart Disease or Stroke ☐ High Cholesterol ☐

Other Endocrine problems_____

Preventive care:

Exercise: ☐ No ☐ Yes→ How many minutes per day? _____How many days per week?_____

Hours of sleep per night?_____

Contraceptive used _____Last menstrual period: _____ Last PAP smear:_____

Last mammogram:_____ Last colonoscopy: _____

Are your immunizations up to date? ☐ Yes ☐ No

Marital Status: Single Occupation: _____

Last Completed or Current Grade in school:_____

Recreational Substance Use:

	Ever Used?	Current use?	Quit date?	How much?	How often?
Tobacco					
Alcohol					
Street Drugs					
Other					

Preferred Pharmacy Name_____

Street _____City_____Zip_____

and/or phone:_____

Current Medications and Dosing (please include vitamins and supplements)

_____

_____

_____

_____

_____

Please continue completing your new patient paperwork by completing the following Patient Health Symptoms form.

Thank you!

Patient Health Symptoms Form

Please check all symptoms that apply.

General

- ☐ Fever or chills
- ☐ Night sweats
- ☐ Change in appetite
- ☐ Fatigue
- ☐ Fainting
- ☐ Poor sleep
- ☐ Unexplained weight loss
- ☐ Weight gain
- ☐ Recent trauma
- ☐ Lumps or bumps
- ☐ Unexplained falls

Musculosketal

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Noisy joints
- ☐ Arthritis
- ☐ Joint deformities

Genitourinary

- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Lack of bladder control
- ☐ Urinating at night
- ☐ Urinating more volume than expected

Eye

- ☐ Visual changes
- ☐ Eye pain
- ☐ Blurred vision
- ☐ Double Vision
- ☐ Blind Spots “floaters”

Gastrointestinal

- ☐ Abdominal pain
- ☐ Cramping
- ☐ Food avoidance
- ☐ Bloating
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting Blood
- ☐ Red blood in stools
- ☐ Black stools

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Crying spells
- ☐ Decreased work/school performance
- ☐ Personality change
- ☐ Mood swings

Neurological

- [ ] Headaches
- [ ] Seizures
- [ ] Confusion
- [ ] Difficulty with balance
- [ ] Difficulty with speech
- [ ] Numbness
- [ ] Tingling
- [ ] Dizziness

Cardiovascular

- [ ] Chest pain
- [ ] Hard to exercise
- [ ] Waking up grasping for air
- [ ] Can't sleep flat
- [ ] Palpitations
- [ ] Rapid heartbeat
- [ ] Pain in legs with walking
- [ ] Swollen ankles

Allergic/Immunologic

- [ ] Anaphylaxis
- [ ] Lymph node swelling
- [ ] Allergic reactions

Respiratory

- [ ] Cough
- [ ] Wheezing
- [ ] Coughing up blood/mucus
- [ ] Shortness of breath

Hematologic

- [ ] Anemia
- [ ] Bruising
- [ ] Unexpected bleeding
- [ ] History of blood transfusion
- [ ] Refused for blood donation

Endocrine

- [ ] Cold intolerance
- [ ] Heat intolerance
- [ ] Excess hunger
- [ ] Excess thirst
- [ ] Excessive hair growth
- [ ] Hair loss
- [ ] Unexplained tanning

Ear, Nose, Mouth Throat

- [ ] Runny nose
- [ ] Ringing in ears
- [ ] Toothache
- [ ] Sore throat
- [ ] Ear ache
- [ ] Hearing loss
- [ ] Sinus problems
- [ ] Nose bleeds
- [ ] Bleeding gums
- [ ] Difficulty swallowing
- [ ] Hoarseness
- [ ] Painful swallowing

Skin/Breasts

- [ ] Itching
- [ ] Hives
- [ ] Rash
- [ ] Sore that won't heal
- [ ] Stretch marks
- [ ] Dark, thick skin at back of neck
- [ ] Eczema
- [ ] Change in moles
- [ ] Acne
- [ ] Dry skin
- [ ] Breast pain
- [ ] Breast lumps
- [ ] Breast discharge

Men Only

- [ ] Erection difficulties
- [ ] Poor sex drive
- [ ] Lump in testicles
- [ ] Penis discharge

Women Only

- [ ] Abnormal PAP
- [ ] Painful periods
- [ ] Spotting
- [ ] Irregular periods
- [ ] Vaginal discharge
- [ ] Hot flashes
- [ ] Painful intercourse
- [ ] Poor sex drive