Rocky Mountain Diabetes Center

New Diabetic Patient Medical History Information

Name:	Date:	Date of Birth:
Primary Care Physician:	Pharmacy:	

We are pleased to welcome you to our office. Eighty-five percent of our patients have diabetes, and caring for diabetes is the major focus of our office. We will do our best to take good care of you and teach you how to take good care of your diabetes.

Medical History

What type of disorder or condition do you have? ☐ Type 1 Diabetes ☐ Type 2 Diabetes
☐ MODY ☐ Pre-diabetes ☐ Insulin Resistance Syndrome ☐ Gestational Diabetes

How long have you had your condition?

How was your condition diagnosed?

Did you have excessive thirst and urination? ☐ Yes ☐ No

How was your condition treated initially?
☐ Diet and weight loss ☐ Pills to lower blood sugars ☐ Insulin ☐ Other _____

How do you rate your control of your condition **over the years**? ☐ Good ☐ Poor

How do you rate your control of your condition **in the past few weeks**? ☐ Good ☐ Poor

What diabetes education have you had in the past?

What sort of diet do you follow now? (check one)
☐ Avoid sweets ☐ Count carbohydrates ☐ Exchange ☐ Eat nutritionally ☐ Other _____

What has happened to your weight since you were diagnosed with your condition?

Have you had a recent measurement of your blood glycohemoglobin (a1c) level (this test tells us what your average blood sugar level has been for the past 3 months)? ☐ Yes, value_____ ☐ No

Do you test your own blood sugar levels? ☐ Yes ☐ No

How high have your blood sugars been on average recently (Circle)?
80-150 150-200 200-300 >300

Do you exercise regularly? ☐ Yes ☐ No; If yes, what type of exercise?_____

Have you ever had ketoacidosis (extremely high blood sugar levels, nausea, vomiting, and rapid breathing requiring hospitalization)? ☐ Yes ☐ No

Have you ever had extremely low blood sugar levels causing unconsciousness? ☐ Yes ☐ No

Have you had problems with infections? (check any that apply)
☐ skin ☐ feet ☐ urinary tract ☐ sinusitis ☐ bronchitis ☐other _____

Have you developed any of the following long-term diabetic complications?

☐Yes ☐No Diabetic retinopathy (diabetic eye disease)
☐Yes ☐No Diabetic nephropathy (diabetic kidney disease)

Diabetic neuropathy

☐Yes ☐No Numbness or tingling in feet
☐Yes ☐No Numbness or tingling in hands
☐Yes ☐No Paralyzed stomach: stomach that won't empty food into intestine
☐Yes ☐No Inability to empty bladder
☐Yes ☐No Leakage of stool from the rectum
☐Yes ☐No Inability to have an erection
☐Yes ☐No Chronic diarrhea
☐Yes ☐No Chronic constipation

Cardiovascular disease

☐Yes ☐No High blood pressure? For how long? _____
☐Yes ☐No Past history of heart attack
☐Yes ☐No Past history of heart catheterization
☐Yes ☐No High cholesterol
☐Yes ☐No Tightness in your calves when walking
☐Yes ☐No Partially blocked neck arteries (carotid artery stenosis)
☐Yes ☐No Have you ever had a stroke?

Diabetic Foot Problems

☐Yes ☐No Have you ever had a foot ulcer?
☐Yes ☐No Do you have thick toenails?
☐Yes ☐No Do you have thick foot calluses?
☐Yes ☐No Are your feet or toes deformed?

Past Medical History

List any surgeries that you have had:

List serious illnesses that you have had:

List serious injuries:

Medications		
Medication	Dose	Frequency
All Current Medications and Supplements		
List medications to which you are allergic:		

Social History	
Marital status: ☐married ☐single ☐widowed ☐divorced	Number of Children:
Occupation:	Religious preference:
Do you drink? ☐Yes ☐No If yes, do you have more than 14 drinks per week? ☐Yes ☐No	
Have you ever smoked? ☐Yes ☐No How many years?_____ Do you smoke now? ☐Yes ☐No How many packs a day?_____	

Family History	
List family members with any of the following (mother, father, son, daughter, brother, sister, MGM, MGF, PGM, PGF):	
Diabetes: Type 1_____ Type 2_____	Cancer:
Stroke:	Thyroid disease:
Coronary Artery disease (heart attacks, bypass surgery, angioplasty/stenting):	

Health Maintenance

Are you up to date on the following:

☐Yes ☐No Pap smear (women only): Date:_____ Result:_____
☐Yes ☐No Mammogram (women only, yearly after age 40): Date:_____ Result:_____
☐Yes ☐No Colonoscopy (every 5-10 years after age 45) Date:_____ Result:_____
☐Yes ☐No Hemoccult: Stool test (yearly after age 50) Date:_____ Result:_____
☐Yes ☐No Prostate Cancer blood test (PSA, men only) Date:_____ Result:_____
☐Yes ☐No Bone density study (women and men) Year?_____ Location:_____

Have you had the pneumonia vaccine (Pneumovac)? ☐Yes ☐No; or Influenza? ☐Yes ☐No

Date of your last eye exam:

Please check (☑) any problems you may be having:

General:
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Headache

Eyes:
- ☐ Blurred Vision
- ☐ Floaters
- ☐ Infection
- ☐ Redness
- ☐ Pain in Eyes

Ears/Nose/Throat:
- ☐ Earache
- ☐ Hearing Loss
- ☐ Sinus Infection
- ☐ Sores in Mouth
- ☐ Sore Throat

Heart:
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heart Racing
- ☐ Heart Pounding
- ☐ Ankle Swelling

Lungs:
- ☐ Asthma
- ☐ Wheezing
- ☐ Cough
- ☐ Stop Breathing at Night (sleep apnea)
- ☐ Use CPAP machine

Bowels:
- ☐ Heartburn
- ☐ Acid Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stools
- ☐ Trouble swallowing
- ☐ Black stools

Kidneys:
- ☐ Burning with Urination
- ☐ Loss of Urine
- ☐ Blood in Urine
- ☐ Difficulty with Urine Flow

Musculoskeletal:
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Back Pain
- ☐ Thin Bones
- ☐ Bone Fractures

Neurologic:
- ☐ Numbness/Tingling
  - o Hands
  - o Feet
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Muscle Weakness

Psychiatric:
- ☐ Anxiety
- ☐ Depression

Hormonal:
- ☐ Thyroid Disease
- ☐ Menstrual Problems
- ☐ Erection Problems
- ☐ Excess Facial Hair
- ☐ Adrenal Disease
- ☐ Pituitary disease

Skin/Breast:
- ☐ Rash
- ☐ Moles
- ☐ Breast Mass
- ☐ Breast Soreness

Blood/Lymph:
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Bleeding Gums

Allergies:
- ☐ Hay Fever
- ☐ Hives
- ☐ New allergies to medication

Do you have any skin lesions that you are worried may be cancerous or pre-cancerous? ☐Yes ☐No

Other problems to discuss with the doctor:
1. _____
2. _____
3. _____