Premier Health
Premier HealthNet

Bull Family Diabetes Center

New Patient Questionnaire

Please help us by filling out this form before your visit with the doctor. If you need help, please call (937) 395-3656.

NAME _____ Date of Birth_____

When were you diagnosed with diabetes? (year and age)	
What was your weight at that time?	
Have you been hospitalized for diabetes? If so, list dates and reason.	
Do you have any complications related to diabetes? (eye, kidney, nerve, heart, please indicate which)	
Have you needed someone else's help, called emergency services or had a car accident due low blood sugars? Please indicate approximate dates.	
What is date of your last diabetic eye exam?	

CIRCLE ALL treatments you have tried for Diabetes:

Drug Name (CIRCLE)	Current use	Past use (dates used)	Reason for Stopping
Metformin, metformin XR, Glumetza, Glucophage XR			
pioglitazone (Actos), rosiglitazone (Avandia)			
acarbose (Precose), miglitol (Glyset)			
glimepiride (Amaryl), glipizide (Glucotrol), glyburide (Micronase, Diabeta, Glynase)			
nateglinide (Starlix), repaglinide (Prandin)			
colesevelam (Welchol)			
bromocriptine (Cycloset)			
exenatide (Byetta), exenatide extended release (Bydureon), liraglutide (Victoza), albiglutide (Tanzeum), dulagutide (Trulicity)			
pramlintide (Symlin)			
sitagliptin (Januvia), saxaglipitin (Onglyza), linagliptin (Tradjenta), alogliptin (Nesina)			
canagliflozin (Invokana), dapagliflozin (Farxiga), empaglifolzin (Jardiance)			
Combinations: Metaglip, Glucovance, Actoplus met, Duetact, Avandaryl, Avandamet, Janumet, Kombiglyze, Jentadueto, Kazano, Oseni, Invokamet, Xigduo, Glyxambi			
HIGHLY CONCENTRATED U-500 regular insulin **Intermediate or long acting insulin**: NPH, glargine (Lantus), detemir (Levemir) **Short or rapid acting insulin** : lispro (Humalog), aspart (NovoLog), glulisine (Apidra), Regular, **Mixed insulin:** Humulin/Novolin 70/30, Humalog Mix 75/25, Humalog Mix 50/50, NovoLog Mix 70/30,			

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General Medical History (check all that apply)

___ Diabetes
___ Cataract(s)
___ Glaucoma
___ Heart disease
___ Heart attack
___ High blood pressure
___ High cholesterol
___ Heart failure
___ Asthma
___ Emphysema or COPD
___ Sleep Apnea
___ Fibromyalgia
___ Reflux
___ Stomach ulcers
___ Intestinal bleeding
___ Liver disease
___ Gastroparesis
___ Pancreatitis
___ Gall Bladder disease
___ Anemia
___ Blood clots
___ Cancer or tumors
___ Kidney disease
___ Kidney stones
___ HIV/AIDS
___ Arthritis
___ Osteoporosis
___ Gout
___ Thyroid problems
___ Seizures
___ Psychiatric illness
___ Stroke

Please write other health problems not listed above.

_____

_____

Hospitalizations and Operations

_____ _____ _____

_____ _____ _____

_____ _____ _____

Current Medications **PLEASE BRING A LIST OF YOUR MEDICATIONS TO *ALL* APPOINTMENTS.** REMEMBER TO INCLUDE INJECTED, INHALED MEDICATIONS, DIABETIC SUPPLIES, VITAMINS, SUPPLEMENTS AND MEDICATIONS PURCHASED OVER-THE-COUNTER.

Medication Allergies List any medication allergies and the type of reaction that occurs.

_____

_____

Immunizations List date completed.

Tetanus booster		Pneumovax (pneumonia)		Influenza (flu)	
Hepatitis B		Shingles			

Family History (check, indicate who)

__ Diabetes
__ High blood pressure
__ High cholesterol
__ Heart Disease
__ Other Cancer
__ Osteoporosis
__ Thyroid problems
__ Thyroid cancer
__ MEN2 syndrome
__Other _____

Social History

Occupation	**Highest level of education**	☐**single** ☐**married** ☐**divorced** ☐**widowed**
Substances used	**Yes or No**	**How Much and What**
Alcohol		
Tobacco		
Addictive drugs		
Do you exercise?	**How Often/What Activities?**	**What Limits Your Physical Activity?**

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Review of Systems (check symptoms you have had recently)

General
___ Activity change
___ Appetite change
___ Chills
___ Sweating
___ Fatigue
___ Fever
___ Unexpected weight change

Head/Ear/Nose/Throat
___ Sinus congestion
___ Dental problems
___ Hearing loss
___ Nosebleeds
___ Postnasal drip
___ Runny nose
___ Sinus pressure
___ Trouble swallowing
___ Voice change

Eyes
___ Eye pain
___ Eye redness
___ Light sensitivity
___ Vision changes

Breathing and Lungs
___ Snoring or apnea
___ Choking
___ Cough
___ Shortness of breath
___ Wheezing

Heart
___ Chest pain/tightness
___ Leg swelling
___ Palpitations
___ Leg pain with walking
___ Heart murmur

Stomach/Intestinal
___ Abdominal bloating
___ Abdominal pain
___ Blood in stool
___ Constipation
___ Diarrhea
___ Nausea
___ Vomiting
___ Liver problem

Gland/Hormone
___ Cold intolerance
___ Heat intolerance
___ Increased thirst
___ Thyroid problem
___ Menopause (women)

Genitourinary
___ Difficulty urinating
___ Painful urination
___ Incontinence
___ Flank pain
___ Frequent urination
___ Blood in urine
___ Urgency
___ Decreased urination
___ Erectile dysfunction (men)

Muscle and Skeletal
___ Joint pains
___ Back pain
___ Walking difficulties
___ Joint swelling
___ Muscle aches

Skin
___ Rash
___ Wound/sores/ulcers
___ Dry skin

Neurological
___ Dizziness or lightheaded
___ Facial droop
___ Headaches
___ Numbness
___ Neuropathic pain
___ Seizures
___ Speech difficulty
___ Passing out/losing consciousness
___ Tremors
___ Weakness

Hematologic
___ Lymph gland swelling
___ Easy bruising
___ Blood clots

Psychiatric
___ Agitation
___ Confusion
___ Poor concentration
___ Depression
___ Hallucinations
___ Hyperactive
___ Nervousness/anxiety
___ Self-injury
___ Sleep disturbance
___ Suicidal thoughts

List additional symptoms or conditions you would like us to know about.

_____

Please bring your medication list, immunization record, blood glucose meter to all visits. Thank you.

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New Patient Health Questionnaire

Demographics Information

Type of Diabetes: ☐ Type 1 ☐ Type 2 (using insulin) ☐ Type 2 (not using insulin)
☐ Gestational ☐ Pre-diabetes ☐ Don't Know

Are you on an insulin pump? ☐ No ☐ Yes Brand Name:_____

Ethnicity: ☐ African-American ☐ Asian-American ☐ Caucasian
☐ Hispanic/Latino ☐ Other _____

What is your Learning style? ☐ Reading (books, pamphlets) ☐ Showing/watching/doing
☐ Listening/talking ☐ Other _____

Have you had diabetes education before? ☐ No ☐ Yes

If yes, what year? _____

Location? _____

Describe education received: _____

_____

Health Assessment and Diabetes Self Management

Height: _____ **Current Weight:** _____ ☐ Stable ☐ Varies

Approximate mont/year of the following exams:

Foot Exam _____ Dilated Eye Exam_____ Dental Exam _____

What was your last A1c? _____ Date _____ ☐ Don't know what this is

Do you check your blood glucose (blood sugar) at home? ☐ No ☐ Yes How often? _____

What is the brand name of your glucose meter? _____

What has been your highest blood glucose reading? _____ **Your lowest?** _____

Do you test for ketones? ☐ No ☐ Yes ☐ Don't know what this is

Do you wear diabetes identification? ☐ No ☐ Yes What type of ID? _____

Do you carry a source of sugar for low blood sugars? ☐ No ☐ Yes _____

Are you on a special diet? ☐ No ☐ Yes

What type of diet do you follow? _____

What time of day do you eat? Breakfast: _____ Lunch: _____ Dinner: _____

Do you snack between meals? ☐ No ☐ Yes How often? _____

Do you skip meals? ☐ No ☐ Yes ☐ Sometimes

How many meals per week do you eat away from home or order take out? _____

What beverages do you drink? _____

What do you most want to learn about diabetes? ☐ Meal Planning/ Counting Carbohydrates
☐ Medication ☐ Using meter ☐ Other _____

Reviewed By: _____ **Date:** _____