Diabetes First Visit

DATE: **YOUR AGE:**

Your Primary Care Physician (Name, Address):

Your Diagnosis of Diabetes

About when were you diagnosed?			
How Diagnosed (Circle One)	Symptoms?	Pregnancy?	Blood Work?
Details of Diagnosis:			
Your Body Wt: ~ 10 Yrs. Before Diagnosis:		Max. Wt. Before Diagnosis:	
Change in Wt. Since Diagnosis:			

Treatment of Diabetes

How closely do you follow **a Diet**	In Past:	Recently:
Details of Diet (Sweets? Calories? Fat content? Carbohydrates? Balanced?):		
How many servings of fruit/vegetables daily?		
How many servings of red meat per week?		
How much do you **Exercise**? (Type, Frequency)		

Do You Take **Pills** for Diabetes?

For how many years did you or have you taken pills?
Current type and dose of pills you take for diabetes:

Do you take **Insulin?**

Never	Yes	Insulin Pump
Current Type, Doses of Insulin:		

How Well Is Your Diabetes Controlled?

Monitoring

In your opinion is your control: Excellent? Pretty Good? Not so Good? Poor?
Do you (test) your blood sugar? How often? A1C ("3 month test")
Self monitoring? No monitoring? Urine testing?
Typical results of self monitoring (What is the range, morning and other times?):
A1C results you know by date:
Compared to the past, is your control: Better? About the same? Worse?

Hypoglycemia (Low Blood Sugar)

About how often do you **feel low?** Daily? Weekly? Monthly? Rarely?
What are your symptoms when low?
Do you get confused? Have you ever been unconscious?
What time of day is most typical?
Are you ever low overnight? Do you wake up?
Have you ever been in a diabetic coma?

Do you have any diabetic complications that you know about?

Yes/No	Problem	Explain details
	Eyes	
	Kidneys	
	Nerve damage (Numb, tingling)	
	(Males) Impotence	
	Diarrhea/Constipation	
	Heart trouble	
	Foot Problems	
	Vaginal Infections (Women)	
	Slow Healing	

What are the main diabetes issues you want help with?

Past Medical History

Are you **allergic** to anything?
What **operations (surgeries)** have you had in your life, and about what year?
What other **medical illnesses** do you have? (Such as high blood pressure, high cholesterol, heart attack, or stroke?)
Please list ALL your **current medications,** with dose, if known:

Family History:

Do you have **diabetes** in your family? (Circle one) Yes No
Relatives with diabetes:
Does **heart disease or stroke** occur at an early age (under 55 years old) in your family?
Yes No
If yes, state which family members, and age:
Does high cholesterol occur in your family? Yes No

Social History:

Marital Status:	Employment:
How many years of schooling have you completed?	Do you have children? How many?

Tobacco / Alcohol / Drug(s) History:		
Tobacco: Never Cigarettes Cigars Snuff Quit? When ? How many years? Quantity:______Number of Years: We DO recommend a smoking cessation program	**Alcohol:** Never Special Occasions 1-3 drinks/week 4-10 drinks/week 11 or more drinks/week	**Illicit Drugs:**

For Women of Childbearing Age:	**Women:**
Contraceptive(s) used: Pregnancy Planning?	# Pregnancies #Terminations or Miscarriages # Deliveries # Children Alive Ages? Illnesses? Babies premature? Weights? Menopause?

REVIEW OF SYSTEMS

(If you answer Yes, please explain):

Fever, weight loss, or other general symptoms?	No	Yes
Trouble with Eyes?	No	Yes
Ears, Nose Mouth, Dental and Throat?	No	Yes
Heart trouble?	No	Yes
Breathing/Lung trouble?	No	Yes
GI Trouble (Such as Ulcers, Stomach pains, Diarrhea)?	No	Yes
Liver Disease (Such as Hepatitis, other liver problems)?	No	Yes
Urine/Kidney problems (such as Infections, Stones, Prostate trouble)?	No	Yes
Bones and Joint Problems (such as Arthritis, Osteoporosis, Fractures)?	No	Yes
Skin Disease?	No	Yes
Neurological Disease (Such as Stroke)?	No	Yes
Psychiatric Disease (Such as Depression, Anxiety)?	No	Yes

Hormonal Disease (Such as Thyroid)?	No	Yes
Blood Disease (Such as Anemia)?	No	Yes

PHYSICAL EXAMINATION

Sex:	**Race:**	**Height:**	**Weight:**

General:					
Vital Signs: BP		Pulse			
Eyes: Dilated:	Yes	No	Retinopathy: Yes	None Noted	
Details:					
	Normal	**Abnormal**	**Details**		
Skin:					
Head:					
Neck:					
Chest:					
Heart:					
Abdomen:					
Extremities:	Normal?	Yes	No		
	Open Foot Lesions	Yes	No		
	Orthopedic Abnormalities?	Yes	No		
Pulses (0=Absent, 2=Normal)		D.P.	P.T.		
	Right:				
	Left:				
Other:					

Neurologic: (0=Absent, 5=Normal)

Gross Peripheral Strength #		Cranial Nerves #
Vibratory Sense #		Proprioception #
Monofilament +/-:	Right	Left
Ankle Reflex:		
Other Neurologic Abnormalities:		

Impressions:

Diabetes: Type I Type II Other Gestational Unclear
Management Issues:
Complications: Retinopathy? Peripheral Neuropathy? Nephropathy?
Impotence? Other Autonomic Neuropathy? Necrobiosis? CAD?
PVD? Foot Lesions? High Blood Pressure? Dyslipidemia
Other?
Other Diagnoses:

Plans:

Screening: A1C? Lipid Profile? Urine Microalbumin?
Referrals: Dietician? Nurse Ed? Ed Program? Ophtho?
Podiatry? Primary Care? Other?
Other Recommendations?

Copy Referring MD? Signature (H&P, Dx, Plan by Attending Physician)