Diabetes Care Center

at Medical Park Family Care, Inc.

INTERNAL REFERRAL DIABETES HISTORY FORM

Name: _____ DOB: _____ Today's Date:_____

What type of diabetes do you have? Please circle:

○ Pre-diabetes ◉ Type 2 diabetes ○ Gestational diabetes

○ Type 1 diabetes/Latent Autoimmune Diabetes of Adults (LADA) ○ Other_____

When were you first diagnosed with diabetes? _____

Were you diagnosed on routine blood work or were you having symptoms?

_____

_____

What was your last hemoglobin A1c? _____Date:_____

MEDICATION

If you take insulin:

When did you first start it?_____

If applicable, please write your insulin sliding scale (ex. 1 unit lowers blood sugar 50 mg/dL or 1:50) and carb ratio (ex. 1 unit covers 10 grams of carb or 1:10):

_____

_____

Please list any diabetes medications (pills and/or insulin) you took in the past and why they were stopped (ex. Allergic reaction, side effect, ineffective):

_____

_____

_____

MONITORING

Do you test your blood sugar? YES or NO

If YES, how often? _____

What is your average blood sugar range in the am: _____

What is your average blood sugar range in the pm: _____

Have you ever had a low sugar reaction (<70 mg/dL)? YES or NO

If YES, can you tell when your blood sugar is getting low? _____

If YES, what symptoms do you have?

_____

At what blood sugar number do you start feeling a low blood sugar? _____

How often do you have low blood sugar? _____

How did you treat it? _____

Do you have any overnight/while asleep? YES or NO

Do you carry a source of sugar with you at all times? YES or NO

Have you ever been given a glucagon shot? YES or NO

Have you ever been hospitalized for your diabetes? YES or NO

If yes, how many times for high sugars? _____

If yes, how many times for low sugars? _____

Have you ever been in the emergency department because of your diabetes? YES or NO

If yes, how many times for high sugars? _____

If yes, how many times for low sugars? _____

MEDICAL HISTORY

Do you have any of the following complications from diabetes? (Please check any that apply)

- ☐ Eye problems (retinopathy)
- ☐ Heart/vascular problems (heart attack, stroke, stents, bypass, peripheral vascular disease)
- ☐ Kidney problems (chronic kidney disease, protein in the urine)
- ☐ Nerve problems (Neuropathy)
- ☐ Foot ulcers or amputations
- ☐ Dental problems
- ☐ Erectile dysfunction or sexual problems

Please explain any of the above:

_____

_____

_____

_____

_____

When was your last eye exam? _____

When was your last dental exam? _____

When was your last foot exam? _____

Have you ever had a pneumonia vaccine? YES or NO If YES, when_____

Did you have a flu shot this year? YES or NO If YES, when_____

Have you ever had a shingles vaccine? YES or NO If YES, when_____

SOCIAL HISTORY

Do you drink alcohol (wine, beer, spirits)? YES OR NO

If yes, what kind and how often?

_____

Do you currently smoke cigarettes or use other tobacco products? YES OR NO

If yes, how much per day? _____

Did you ***ever*** smoke cigarettes or use other tobacco products regularly? YES OR NO

If yes, how much and when did you quit?_____

Please describe the timing and contents of your meals and snacks on an average day:

_____

_____

_____

Do you drink soda, sweet tea or other sweetened beverages? YES or NO

If yes, how many per day or week?_____

How often do you eat out or have "fast food"?_____

Do you exercise regularly? YES or NO

If YES, what type?_____

How many times per week? _____

How long each time?_____

If NO, why are you not exercising? _____

FAMILY HISTORY

Examples: diabetes; high blood pressure; high cholesterol; heart/vascular disease (stroke, heart attack, coronary bypass, cardiac stents); autoimmune disease (type 1 diabetes, celiac disease, Hashimoto's thyroid disease, rheumatoid arthritis, lupus, MS); thyroid disorder; cancer.

Mother _____

Maternal grandmother_____

Maternal grandfather_____

Maternal siblings (your aunts and uncles)_____

Father _____

Paternal grandmother_____

Paternal grandfather_____

Paternal siblings (your aunts and uncles)_____

Your siblings_____

REVIEW OF SYSTEMS

General	□ Unintentional change in weight □ Fatigue □ Fever or chills □ Trouble sleeping
Endocrine	□ Heat or cold intolerance □ Hair and nail changes □ Sweating □ Frequent urination □ Increased thirst □ Increased appetite
Cardiac	□ Chest pain or discomfort □ Tightness □ Palpitations □ Shortness of breath with activity □ Difficulty breathing lying down □ Swelling (edema) □ Sudden awakening from sleep with shortness of breath
Vascular	□ Calf pain with walking □ Leg cramping □ Poor wound healing □ Erectile dysfunction or sexual problems
Eyes	□ Vision changes □ Glasses or contacts □ Blurry or double vision □ Flashing lights
Respiratory	□ Shortness of breath □ Wheezing □ Snoring □ Interrupted breathing during sleep (apnea)
Neurologic	□ Numbness □ Tingling/burning □ Weakness □ Foot ulcers