GREENSBORO ENDOCRINOLOGY
Caring for patients with diabetes and other endocrine disorders

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Initial Diabetes Assessment

To help us meet your needs, please fill out this entire form to the best of your ability, and be sure we receive it at least 3 business days before your consult appointment so we can prepare for your visit.

Please print legibly. *Completed by* ❑ *Patient* ❑ *Other* _____

General Information

Name: _____ Today's date: _____

❑ Male ❑ Female Birthdate: _____ Age: _____ Appointment date: _____

Who referred you to our practice? _____

Home Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

❑ Spouse or ❑ Parent Name: _____ With whom do you live? _____

Your employer: _____ Occupation: _____

What hours do you work? _____ Highest education level achieved: _____

Have you ever seen a dietitian? ❑ No ❑ Yes. If yes, where and when? _____

Have you ever seen a diabetes educator? ❑ No ❑ Yes If yes, where and when? _____

Have you ever seen an endocrinologist? ❑ No ❑ Yes If yes, who and when? _____

Possible barriers to learning: ❑ Vision ❑ Hearing ❑ Literacy ❑ Memory ❑ None

Does any person help you with your diabetes care? ❑ No ❑ Yes. If yes, who? _____

My Diabetes History

When was your diabetes diagnosed? _____ When you were first diagnosed, what was your blood sugar? _____ Were you having symptoms? ❑ No ❑ Yes. If yes, explain _____

Diabetes type: ❑ Type 1 ❑ Type 2 ❑ Don't know

Do you use insulin? ❑ No ❑ Yes. If yes, when did you first start on insulin? _____

How would you describe your recent blood sugar control?

❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Don't know

Do you wear a diabetes medical identification emblem (necklace or bracelet)? ❑ No ❑ Yes

Are you a member of the American Diabetes Association (membership benefits include receiving *Diabetes Forecast* magazine)? ❑ No ❑ Yes

My Diabetes Medications

Please bring all medicine bottles with you

Insulin: ❑ Insulin pump (please complete separate "Insulin Pump Patient Questionnaire")

Mark here if using insulin pen ↓	Units before breakfast	Units before lunch	Units before supper	Units before bedtime
Insulin (long-acting) ❑ Pen ❑ Lantus ❑ Levemir ❑ Toujeo				
Insulin (rapid-acting) ❑ Pen ❑ Humalog ❑ Novolog ❑ Apidra				
Insulin (other type) ❑ Pen ❑ _____				

Diabetes Pills: Mark "Past" (no longer taking) or "Present" (currently taking)

Past	Present		Dose (mg)	Time(s) of day	Started (year)
❑	❑	Glyburide	_____	_____	_____
❑	❑	Glipizide	_____	_____	_____
❑	❑	Glipizide XL	_____	_____	_____
❑	❑	Glimepiride	_____	_____	_____
❑	❑	Metformin	_____	_____	_____
❑	❑	Metformin ER	_____	_____	_____
❑	❑	Actos (pioglitazone)	_____	_____	_____
❑	❑	Januvia	_____	_____	_____
❑	❑	Onglyza	_____	_____	_____
❑	❑	Tradjenta	_____	_____	_____
❑	❑	Nesina	_____	_____	_____
❑	❑	Invokana	_____	_____	_____
❑	❑	Farxiga	_____	_____	_____
❑	❑	Jardiance	_____	_____	_____
❑	❑	Precose	_____	_____	_____
❑	❑	Welchol	_____	_____	_____
❑	❑	Cycloset	_____	_____	_____
❑	❑	Combo pill (specify)	_____	_____	_____

Diabetes Injections (Non-Insulin): Mark "Past" (no longer taking) or "Present" (currently taking)

Past	Present		Dose (mg)	Time(s) of day	Started (year)
❑	❑	Byetta	_____	_____	_____
❑	❑	Victoza	_____	_____	_____
❑	❑	Bydureon	_____	_____	_____
❑	❑	Tanzeum	_____	_____	_____
❑	❑	Trulicity	_____	_____	_____

All other medications (prescription & non-prescription) that you currently take:

	Drug Name	Dose (mg)	When taken (times of day)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Please list any medications (prescription and non-prescription) that you are **allergic** to, or have had **side effects** from: ❑ None

Drug Name	Describe allergy or side effect

Pharmacy:

Mail order: _____ ❑ Preferred

Local: _____ ❑ Preferred

My Nutrition

In the last few years, what has been your highest weight? _____ (When? _____)

In the last few years, what has been your lowest weight? _____ (When? _____)

Your current height? _____ Your current weight? _____

Please check any of the following that apply to your meal planning:

❑ Use exchanges ❑ Count calories ❑ Count carbohydrates

❑ Measure foods ❑ Weigh meats

Who does most of your food preparation at home? _____

How many times per week do you typically eat out at restaurants? _____

How many times per week do you typically eat "take out" meals? _____

What three restaurants do you eat at (or take out from) most often?

1. _____ 2. _____ 3. _____

How many ounces of sugar-sweetened beverages (such as sweet tea, regular sodas, and fruit juice) do you drink per day? _____ ounces, or ❑ none

Please list a typical day's food and beverage intake:

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Snacks: _____

_____

Nutrition questions you would like answered: _____

_____

My Exercise

Do you exercise? ❑ No ❑ Yes. If yes, what type(s) of exercise? _____

I exercise about _____ times per week for about _____ minutes each time.

What time of day do you exercise? _____

I would say the intensity of my exercise is ❑ mild ❑ moderate ❑ vigorous

Exercise questions you would like answered: _____

_____

Monitoring My Diabetes

Please bring your blood glucose meter with you to each visit

Do you test your blood sugars? ❑ No ❑ Yes. If yes, how often? _____ times per day.

Meter: ❑ OneTouch Ultra 2 ❑ Accu-Chek Aviva ❑ FreeStyle Lite ❑ Other: _____

❑ OneTouch Verio IQ ❑ Accu-Chek Nano ❑ Bayer Contour

Do you keep a written record of results? ❑ No ❑ Yes Do you download results? ❑ No ❑ Yes

Current meter averages (as displayed): 7 days: _____ 14 days: _____ 30 days: _____

What is your typical range of blood sugar results?

Before breakfast: _____ After breakfast: _____

Before lunch: _____ After lunch: _____

Before supper: _____ After supper: _____

Bedtime: _____

My A1c usually runs about: _____. My most recent A1c was: _____ on (date) _____.

Hypoglycemia

On your current diabetes medicines, do you ever have hypoglycemia (low blood sugar or insulin reaction) symptoms? ❑ No ❑ Yes.

If so: How often? _____

Any particular time of day? _____

Typical low blood sugar symptoms: _____

Typical low blood sugar treatment: _____

Do you have trouble recognizing when your blood sugar is too low? ❑ No ❑ Yes

Have you ever had a severe low blood sugar episode (needing help)? ❑ No ❑ Yes

Diabetes Complications

Do you have any long-term complications from your diabetes (such as eye, kidney or nerve damage; heart problems or stroke; or foot problems) that you know about? ❑ No ❑ Yes

If so, please explain:

_____

_____

_____

_____

When was your last eye exam? _____ Eye doctor name: _____

Do you see a podiatrist (foot doctor)? ❑ No ❑ Yes. If yes, who? _____

Other Health History

Do you smoke? ❑ Never did ❑ Quit (when? _____) ❑ Yes

At what age did you start smoking? _____ Now smoke _____ packs per day.

Do you drink alcohol? ❑ No ❑ Yes. If so, what do you drink? How much? How often?

_____

Do you use recreational drugs? ❑ No ❑ Yes. If so, what do you use? How much? How often?

_____

Please list any other past or current medical problems: ❑ None

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

Please list any surgeries (and estimated dates): ❑ None

1.	4.
2.	5.
3.	6.

Primary care provider: _____

Please list any other doctors you see: ❑ None

1.	4.
2.	5.
3.	6.

Symptom Checklist

□ I am pregnant or may be pregnant

Please check and explain any symptoms you have had recently:

General
□ Appetite increase
□ Appetite decrease
□ Weight loss
□ Weight gain
□ Excessive thirst
□ Fatigue (tired)
□ Unexplained fevers
□ Heat intolerance
□ Cold intolerance
□ Excessive sweating
□ Trouble sleeping
□ Trouble concentrating

Skin
□ Rashes
□ Sores
□ Easy bruising
□ Itching
□ Dryness
□ Color changes
□ Hair changes
□ Nail changes
□ Yellow skin or eyes

Eyes
□ Glasses or contacts
□ Vision loss
□ Eye pain
□ Eye redness
□ Blurred vision
□ Double vision
□ Flashing lights
□ Glaucoma
□ Cataracts

Ears
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Ear drainage

Nose
□ Stuffiness
□ Discharge
□ Hay fever
□ Sinus pain

Mouth and Throat
□ Full dentures
□ Partial dentures
□ Bleeding gums
□ Sore tongue
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Non-healing sores
□ Last dental visit date:

Neck
□ Enlarged thyroid (goiter)
□ Lumps
□ Swollen lymph nodes

Breasts
□ Lumps
□ Pain
□ Discharge
□ Breastfeeding currently
□ Last mammogram date:

Respiratory
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing
□ Painful breathing

Cardiovascular
□ High blood pressure
□ Chest pain, discomfort or tightness
□ Palpitations (heart racing or skipping)
□ Shortness of breath with activity
□ Difficulty breathing lying down
□ Sudden awakening from sleep short of breath
□ Swelling in legs or feet
□ Calf pain with walking

Gastrointestinal
□ Swallowing trouble
□ Heartburn
□ Nausea
□ Vomiting
□ Abdominal pain
□ Change in bowel habits
□ Constipation
□ Diarrhea
□ Rectal bleeding
□ Black stools
□ Last colonoscopy date:

Urinary
□ Frequent urination
□ Urgency
□ Burning or pain
□ Blood in urine
□ Decreased urine flow
□ Incontinence (leaking)
□ Kidney stones (ever)

Reproductive Health
□ Menstrual irregularities
□ Menopause symptoms
□ Sexual problems

Musculoskeletal
□ Muscle pain
□ Muscle cramps
□ Joint pain
□ Joint swelling
□ Neck pain
□ Back pain

Neurologic
□ Headaches
□ Dizziness
□ Muscle weakness
□ Numbness
□ Tingling
□ Tremor

Mental Health
□ Nervousness or anxiety
□ Stress
□ Depression

Family History

Please list health problems in your family, such as:

- ✓ Diabetes (include “type 1” or “type 2” and age of diagnosis if known)
- ✓ High cholesterol
- ✓ High blood pressure
- ✓ Heart disease
- ✓ Stroke
- ✓ Thyroid problems
- ✓ Cancer (include type if known)
- ✓ Depression

Include cause of (and age at) death if known.

	Year of Birth	Healthy	Died	Health problems:
Father		❑	❑	
Mother		❑	❑	
Brother 1		❑	❑	
Brother 2		❑	❑	
Brother 3		❑	❑	
Brother 4		❑	❑	
Sister 1		❑	❑	
Sister 2		❑	❑	
Sister 3		❑	❑	
Sister 4		❑	❑	
Son 1		❑	❑	
Son 2		❑	❑	
Son 3		❑	❑	
Son 4		❑	❑	
Daughter 1		❑	❑	
Daughter 2		❑	❑	
Daughter 3		❑	❑	
Daughter 4		❑	❑	

My Concerns

Please circle one response to each statement using this scale:

1 - Strongly agree
2 - Somewhat agree
3 - Not sure
4 - Somewhat disagree
5 - Strongly disagree

I am satisfied with my present level of understanding of diabetes:	1 2 3 4 5
I understand the importance of good blood sugar control:	1 2 3 4 5
I can accurately measure and record my own blood sugar:	1 2 3 4 5
I know what to do with the results of my blood sugar tests:	1 2 3 4 5
I am careful with my meal plan:	1 2 3 4 5
I exercise on a regular basis:	1 2 3 4 5
I am satisfied with my present weight:	1 2 3 4 5
If on insulin, I know how to adjust my insulin:	1 2 3 4 5
I know what to do when my blood sugar is too high:	1 2 3 4 5
I know what to do when my blood sugar is too low:	1 2 3 4 5
I think stress affects my diabetes:	1 2 3 4 5
I worry a lot about my diabetes:	1 2 3 4 5
I wish I was better motivated to take care of myself:	1 2 3 4 5
My family is concerned about my diabetes:	1 2 3 4 5
I want to be an active participant in my diabetes care:	1 2 3 4 5

What's the hardest thing about having diabetes and having to manage it every day? _____

_____

What do you think are your greatest diabetes care problems? _____

_____

What do you think are your greatest strengths? _____

_____

Other comments you would like to make to help us meet your needs? _____

_____

_____

_____

Thank you. Please be sure to return completed form promptly.

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