ENDOCRINOLOGY CONSULTANTS
OF EAST TENNESSEE
Balanced Care. Better Life.

Name: _____ Date of Birth: ___ /___ /_____ Today's Date: ___ /___ /_____

New Diabetic Patient Health Questionnaire

*** Please complete this form and bring it with you to your appointment. ***

Diabetes History

1. What year were you diagnosed with diabetes? _____
2. Who diagnosed you with diabetes: ☐ primary care provider ☐ specialist provider ☐ hospital
3. What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ pre-diabetes ☐ unsure
4. Relatives with diabetes: ☐ mother ☐ father ☐ brother ☐ sister ☐ grandmother ☐ grandfather

High / Low Blood Glucose

5. Have you ever been to the emergency room or been hospitalized for high blood sugar?
   ☐ Yes ☐ No (If no, skip to question 8)
6. How many times have you been hospitalized for high blood sugar? _____
7. When was the most recent hospitalization for high blood sugar? _____
8. Do you ever have low blood sugar? ☐ Yes ☐ No (If no, skip to question 14)
9. Are you aware when you are having low blood sugar? ☐ Yes ☐ No
10. What time of day does this typically occur?
    ☐ before meals ☐ after meals ☐ morning ☐ afternoon ☐ evening ☐ during sleep
11. How often does this occur? ☐ 1-2x per day ☐ 1-2x per week ☐ 1-2x per month
12. Do you carry glucose tablets or candy with you to treat low blood glucose? ☐ Yes ☐ No
13. Have you ever needed help to treat a low blood sugar? ☐ Yes ☐ No
14. Do you have a glucagon kit? ☐ Yes ☐ No (If no, skip to question 17)
15. Have you ever used a Glucagon kit: ☐ Yes ☐ No
16. Does a family member or friend know how to use the glucagon kit? ☐ Yes ☐ No
17. Do you wear a medical alert bracelet? ☐ Yes ☐ No

Complications

18. Who is your eye doctor (ophthalmologist or optometrist)? _____
19. When was your last dilated eye exam? ___ /___ /_____
20. Have you ever been told you have diabetes related eye damage (retinopathy)? ☐ Yes ☐ No
21. Have you ever had laser surgery on your eyes? ☐ Yes ☐ No
22. Do you see a heart doctor (cardiologist)? ☐ Yes ☐ No Name: _____
23. When was your last stress test: ___ /___ /_____ heart catheterization: ___ /___ /_____
24. Have you ever had a heart attack? ☐ Yes ☐ No stroke? ☐ Yes ☐ No
25. Have you ever been told you have coronary artery disease? ☐ Yes ☐ No
26. Have you ever been told you have high cholesterol or triglycerides? ☐ Yes ☐ No
27. Have you ever been told you have high blood pressure? ☐ Yes ☐ No
28. Do you see a kidney doctor (nephrologist)? ☐ Yes ☐ No Name: _____
29. Have you ever been told you have kidney damage or protein in your urine? ☐ Yes ☐ No
30. Have you ever collected a 24 hour urine specimen? ☐ Yes ☐ No
31. What medicine do you use for pain or discomfort? ☐ Ibuprofen ☐ Tylenol ☐ Aleve
32. Do you have constipation? ☐ Yes ☐ No diarrhea? ☐ Yes ☐ No

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33. If you are male, do you have problems getting erections? ☐ Yes ☐ No
34. Have you tried any of the following medications? ☐ Viagra ☐ Levitra ☐ Cialis
35. Were the medications effective? ☐ Yes ☐ No
36. If female, do you have frequent vaginal yeast infections? ☐ Yes ☐ No
37. Do you have burning, tingling or numbness in your feet? ☐ Yes ☐ No
38. Do you have any sores or nail problems? ☐ Yes ☐ No

Treatment

39. Do you or have you ever taken pills for diabetes? ☐ Yes ☐ No (If no, skip to question 43)
40. When did you start taking pills? _____
41. What pills have you taken in the past? _____ ☐ Don't know
42. What pills are you taking now? _____
43. Do you take insulin? ☐ Yes ☐ No (If no, skip to question 47)
44. What type of insulin do you take? _____
45. How many units do you take at:
    Breakfast _____
    Lunch _____
    Dinner _____
    Bedtime _____
46. Where do you give your injections? ☐ abdomen ☐ arms ☐ legs ☐ bottom

Nutrition & Exercise

47. Have you ever attended diabetes education classes? ☐ Yes ☐ No (If no, skip to question 50)
48. Where did you attend diabetes education classes? _____
49. When did you attend diabetes education classes? _____
50. Have you ever had an appointment with a dietician? ☐ Yes ☐ No (If no, skip to question 53)
51. When did you have an appointment with a dietician? _____
52. Where did you have an appointment with a dietician? _____
53. Do you follow a special diet? ☐ Yes ☐ No ☐ I try but I have difficulty
54. Do you know how to count carbohydrates? ☐ Yes ☐ No
55. Do you exercise? ☐ Yes ☐ No (If no, skip to question 59)
56. What type of exercise do you do?
    ☐ walking/running ☐ biking ☐ swimming ☐ aerobics ☐ weightlifting ☐ other _____
57. How many times per week do you exercise? ☐ 1-2x ☐ 3-4x ☐ 5 or more
58. How long do you exercise? ☐ 10-15 min ☐ 20-30 min ☐ 30-45 min ☐ 45 min or more
59. Have you gained weight in the past year? ☐ Yes ☐ No ☐ Unsure
60. What is your desired weight? _____ lbs
61. What is the least you have weighed? _____ lbs Most you have weighed? _____ lbs
62. Who do you live with? ☐ self ☐ spouse ☐ parent ☐ children ☐ friend ☐ other
63. Who grocery shops & cooks? ☐ self ☐ spouse ☐ parent ☐ children ☐ friend ☐ other
64. Does mood or stress affect your eating habits? ☐ Yes ☐ No
65. How many times per week do you eat at restaurants? ☐ rarely ☐ 1-2x ☐ 3-4x ☐ 5 or more
66. What beverages do you drink?
    ☐ water ☐ regular soda ☐ diet soda ☐ unsweet tea or coffee ☐ sweet tea ☐ milk
67. Do you drink alcohol? ☐ Yes ☐ No (If no, skip to question 70)
68. What type of alcohol do you drink? ☐ beer ☐ wine ☐ liquor

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69. How many drinks per week? ☐ 0-1 ☐ 2-4 ☐ 5-7 ☐ 8 or more
70. How many meals per day do you eat? ☐ 1 ☐ 2 ☐ 3 ☐ 4
71. How many snacks per day do you eat? ☐ 1 ☐ 2 ☐ 3 ☐ 4
72. Do you add salt to your food? ☐ Yes ☐ No

Health Maintenance

73. Do you check your blood sugar with a blood glucose meter? ☐ Yes ☐ No
74. What type of meter do you use? ☐ OneTouch ☐ Accuchek ☐ Bayer ☐ Freestyle ☐ Relion ☐ TrueTest ☐ Other _____
75. How many times per day do you test? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more
76. What is the range of your blood sugar readings? ☐ <70 ☐ 70-100 ☐ 100-150 ☐ 150-200 ☐ 200-250 ☐ 250-300 ☐ 300-350 ☐ 350-400 ☐ 400+
77. Have you received a pneumonia vaccine (Pneumovax-23)? ☐ Yes ☐ No ☐ Unsure
    Date: ___ /___ /_____
78. Have you received a pneumonia vaccine (Prevnar 13)? ☐ Yes ☐ No ☐ Unsure
    Date: ___ /___ /_____
79. Do you receive a flu vaccine every year? ☐ Yes ☐ No ☐ Unsure
80. Have you received vaccination for Hepatitis B? ☐ Yes ☐ No

Past Medical History (List all diagnosed conditions or diseases)

_____

_____

_____

_____

Past Surgical History (List all surgeries and approximate dates)

Surgery	Approximate Date

Social History

Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed ☐ separated

Highest Education Level: ☐ grade school ☐ high school ☐ college ☐ graduate school

Occupation: _____

Smoking Status: ☐ never ☐ former (quit date: ___ /___ /_____) ☐ current every day

Current Smokers: Type: ☐ cigarettes ☐ cigar ☐ vapor ☐ smokeless tobacco

Number of cigarettes/cigars per day: _____

Alcohol: ☐ never ☐ occasional ☐ daily number of drinks per week: _____

Illegal Drugs: ☐ never ☐ occasional ☐ daily

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Family History (List major health problems, diabetes, cancer, heart disease, thyroid disorder etc.)

☐ Family History Unknown

Family Member	Living / Deceased	Age of Death	Cause of Death / Health Problems
Mother	☐ Living ☐ Deceased		☐ None
Father	☐ Living ☐ Deceased		☐ None
(Circle appropriate family member below)			
Sister Brother Child	☐ Living ☐ Deceased		☐ None
Sister Brother Child	☐ Living ☐ Deceased		☐ None
Sister Brother Child	☐ Living ☐ Deceased		☐ None
Sister Brother Child	☐ Living ☐ Deceased		☐ None
Sister Brother Child	☐ Living ☐ Deceased		☐ None

Medication Allergies (List all medication allergies, including reaction)

☐ No known drug Allergies

Name of Medication	Type of Reaction (rash, shortness of breath)

Medication List (List all current medications, including supplements and over the counter)

☐ Not currently taking any medications

Name of Medication	Dose	Instructions

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Medication List Cont'd

Name of Medication	Dose	Instructions

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Review of Systems

General	Yes	No
weight loss	☐	☐
weight gain	☐	☐
loss of appetite	☐	☐
fever/chills	☐	☐
sweating	☐	☐
weakness/fatigue	☐	☐
difficulty sleeping	☐	☐

Comments:

Eyes	Yes	No
eye irritation	☐	☐
eye discharge	☐	☐
eye pain	☐	☐
light sensitivity	☐	☐
loss of vision	☐	☐
blurred vision	☐	☐
double vision	☐	☐

Comments:

Ear, Nose, Throat / Neck	Yes	No
ear pain	☐	☐
ear discharge	☐	☐
loss of hearing	☐	☐
ringing in ears	☐	☐
nasal congestion	☐	☐
nasal discharge	☐	☐
sinus pain	☐	☐
nosebleeds	☐	☐
hoarseness	☐	☐
sore throat	☐	☐
difficulty swallowing	☐	☐
neck pain	☐	☐
neck swelling	☐	☐

Comments:

Cardiovascular	Yes	No
high blood pressure	☐	☐
low blood pressure	☐	☐
☐	☐	

Cardiovascular Cont'd	Yes	No
irregular heart rate	☐	☐
chest discomfort/pain	☐	☐
shortness of breath	☐	☐
fainting	☐	☐
swelling of hands/feet	☐	☐
leg cramps	☐	☐

Comments:

Respiratory	Yes	No
cough	☐	☐
coughing up blood	☐	☐
shortness of breath	☐	☐
wheezing	☐	☐

Comments:

Gastrointestinal	Yes	No
abdominal pain	☐	☐
abdominal bloating	☐	☐
loss of appetite	☐	☐
indigestion	☐	☐
gas	☐	☐
nausea	☐	☐
vomiting	☐	☐
constipation	☐	☐
hemorrhoids	☐	☐
diarrhea	☐	☐
blood in stool	☐	☐

Comments:

Genitourinary	Yes	No
frequent urination	☐	☐
pain/burning with urination	☐	☐
urgent urination	☐	☐
urinary incontinence	☐	☐
nighttime urination	☐	☐
difficulty starting urine flow	☐	☐
blood in urine	☐	☐
heavy menstrual periods	☐	☐
painful menstrual periods	☐	☐

Name: _____ Date of Birth: ___ /___ /_____

Genitourinary Cont'd	Yes	No
irregular menstrual periods	☐	☐
pelvic pain	☐	☐
lack of sex drive	☐	☐
erectile dysfunction	☐	☐

Comments:

Muscles/Joints	Yes	No
muscle or joint stiffness	☐	☐
muscle or joint pain	☐	☐
muscle or joint swelling	☐	☐
muscle weakness	☐	☐
muscle cramps	☐	☐
back pain	☐	☐
knee pain	☐	☐
hip pain	☐	☐

Comments:

Skin/Hair/Nails	Yes	No
rash	☐	☐
itching	☐	☐
dryness	☐	☐
lesions	☐	☐
wounds slow to heal	☐	☐
change in nails	☐	☐
change in skin color	☐	☐
hair loss	☐	☐
excessive hair growth	☐	☐
acne	☐	☐
flushing	☐	☐
excessive sweating	☐	☐

Comments:

Neurologic	Yes	No
weakness	☐	☐
dizziness	☐	☐
seizures	☐	☐
headaches	☐	☐
pain/numbness hands/feet	☐	☐
tremors	☐	☐
loss of consciousness	☐	☐
memory loss	☐	☐
personality changes	☐	☐

Neurologic Cont'd	Yes	No
difficulty with concentration	☐	☐
difficulty with speaking	☐	☐
poor balance	☐	☐

Comments:

Mental Health	Yes	No
anxiety	☐	☐
depression	☐	☐
hallucinations	☐	☐
suicidal thoughts	☐	☐
alcohol/substance abuse	☐	☐
confusion	☐	☐

Comments:

Endocrine	Yes	No
high blood sugar	☐	☐
low blood sugar	☐	☐
excessive hunger	☐	☐
excessive thirst	☐	☐
cold intolerance	☐	☐
heat intolerance	☐	☐
change in hat or ring size	☐	☐
loss of height	☐	☐
bone fractures	☐	☐

Comments:

Blood/Lymphatic	Yes	No
nosebleeds	☐	☐
bleeding gums	☐	☐
bruising	☐	☐
swollen lymph nodes	☐	☐
painful lymph nodes	☐	☐
recurrent infections	☐	☐

Comments:

Allergies/Immunologic	Yes	No
hives	☐	☐
seasonal allergies	☐	☐
HIV exposure	☐	☐

Comments: