

## New Patient Application and Case History (Diabetes Type II)

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F DOB \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ e-mail: \_\_\_\_\_  
May we leave a voice mail? Y N Height \_\_\_\_\_ Weight: \_\_\_\_\_  
How Did You Hear About Us? \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Present Complaints

1. Main Problem(s): \_\_\_\_\_  
\_\_\_\_\_
2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : \_\_\_\_\_  
\_\_\_\_\_
3. When were you diagnosed with Type II diabetes: \_\_\_\_\_  
What diagnostic tools were used to achieve your diagnosis:  
\_\_\_\_\_  
\_\_\_\_\_
4. What are the three things your condition has caused you to miss most:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Symptoms(list all):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Severity of problem (circle):  
Minimal (annoying but causing no limitation)  
Slight (tolerable but causing a little limitation)  
Moderate (sometimes tolerable but definitely causing limitation)  
Severe (causing significant limitation)  
Extreme (causing near constant limitation (>80% of the time))
7. What relieves your symptoms or causes them to return:  
\_\_\_\_\_  
\_\_\_\_\_
8. Describe the first time you remember having symptoms:  
\_\_\_\_\_  
\_\_\_\_\_
9. If your symptoms include pain:  
What is the quality (sharp, dull, stabbing, color, etc.): \_\_\_\_\_  
Does the pain radiate: Y N where: \_\_\_\_\_  
\_\_\_\_\_
10. Do your symptoms occur at a specific time, place, or environment: Y N  
When and for how long do symptoms last each episode:  
\_\_\_\_\_  
\_\_\_\_\_
11. What types of treatment have you received:  
Prescription/Drug therapy \_\_\_\_\_  
Nutritional \_\_\_\_\_  
Alternative/Holistic \_\_\_\_\_
12. List your health goals in order of Importance:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10
13. What are you hoping happens today as a result of your consultation:  
\_\_\_\_\_  
\_\_\_\_\_
14. How often are you aware of your main problem (circle one):  
Occasionally (25% of the time) Frequently (75% of the time)  
Intermittently (50% of the time) Constantly (100% of the time)

Name \_\_\_\_\_ DOB: \_\_\_\_\_

15. If you cannot find a solution to your problem what do you think will happen?

\_\_\_\_\_  
\_\_\_\_\_

16. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?

Work:            Y   N            Describe: \_\_\_\_\_  
Family:         Y   N            Describe: \_\_\_\_\_  
Leisure Activities   Y   N            Describe: \_\_\_\_\_

**Blood Sugar**

HIGHEST your blood sugar gets WITHOUT medication \_\_\_\_\_                      HIGHEST your blood sugar gets WITH medication \_\_\_\_\_  
LOWEST your blood sugar gets WITHOUT medication \_\_\_\_\_                      LOWEST your blood sugar gets WITH medication \_\_\_\_\_

**Medications**

(List all prescription, over-the-counter, **botanicals, homeopathic, and supplements**)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical and Social History**

Surgeries/Hospitalizations	Date	Trauma	Date
_____		_____	
_____		_____	
_____		_____	
Past/Recent Illness	Date	Marital Status: S/ M/ W/Sep./D	Spouse _____
_____		Children / ages:	_____
_____			
Family History (mother, father, siblings, spouse, children)	Date	Do you use: Alcohol Y N	Tobacco Y N      Caffeine Y N
_____		___ drinks/week	___ pack/day      ___ cups/day
_____			

**Review of Systems: Past and Current**

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

**CONSTITUTIONAL**

- P C Fatigue
- P C Recent weight change
- P C Fever

**EYES**

- P C Blurred/double vision
- P C Glasses/contacts
- P C Eye disease or injury

**EAR/NOSE/MOUTH/THROAT**

- P C Swollen glands in neck
- OTHER**

- P C Hearing loss or ringing
- P C Earaches or drainage
- P C Chronic sinus problems or rhinitis
- P C Nose bleeds
- P C Mouth sores / Bleeding gums
- P C Bad breath / bad taste
- P C Sore throat or voice change

**CARDIOVASCULAR**

- P C High or Low Blood Pressure
- P C Shortness of breath walking/lying
- P C Heart disease
- P C Chest pain or angina pectoris
- P C Palpitation
- P C Mitral Valve Prolapse
- P C Feet or ankle swelling
- P C Shortness of breath
- P C Spitting up blood

**PSYCHIATRIC**

- P C Insomnia
- P C Memory loss or confusion
- P C Nervousness
- P C Depression

**GENITOURINARY**

- P C Frequent urination
- P C Burning or painful urination
- P C Blood in urine
- P C Change in force or strain urinating
- P C Kidney stones
- P C Sexual difficulty
- P C Male : testicle pain
- P C Female: pain / irregular periods
- P C Female: pregnant
- P C Bladder Infections
- P C Kidney Disease

- P C Hemorrhoids

**GASTROINTESTINAL**

- P C Abdominal pain
  - P C Nausea or Vomiting
  - P C Rectal bleeding/blood in stool
  - P C Painful bm / constipation
  - P C Ulcer
  - P C Change in bowel movement
  - P C Frequent diarrhea
  - P C Loss of appetite
- RESPIRATORY**
- P C Chronic or frequent cough
  - P C Spitting up blood
  - P C Pneumonia / Bronchitis
  - P C Shortness of breath
  - P C Wheezing
  - P C Asthma

**ENDOCRINE**

- P C Glandular or hormone problem
- P C Excessive thirst or urination
- P C Heat or cold intolerance
- P C Skin becoming dryer
- P C Change in hat or glove size
- P C Diabetes
- P C Thyroid Disease

**MUSCULOSKELETAL**

- P C Back pain
- P C Joint pain
- P C Joint stiffness and swelling
- P C Muscle pain or cramps
- P C Muscle or joint weakness
- P C Difficulty walking
- P C Cold extremities

**INTEGUMENTARY (skin, breast)**

- P C Change in skin color
- P C Change in Hair or Nails
- P C Varicose veins
- P C Breast pain / discharge
- P C Breast lump
- P C Hives or Eczema
- P C Rash or itching

**NEUROLOGICAL**

- P C Freq./ recurring headaches
- P C Migraine headache
- P C Convulsions or seizures
- P C Numbness or tingling
- P C Tremors
- P C Paralysis
- P C Head injury
- P C Light headed or dizzy
- P C Stroke

**HEMATOLOGIC/LYMPHATIC/**

- P C Slow to heal after cuts
- P C Easy bleeding or bruising
- P C Anemia
- P C Phlebitis
- P C Past transfusion
- P C Enlarged glands
- P C Blood or Plasma Transfusions
- P C Hepatitis
- P C Cancer
- P C Infectious Mono
- P C AIDS or HIV+
- P C Venereal
- P C Chicken pox

**ALLERGIES / OTHER** (drugs, food, or environmental) \_\_\_\_\_

\_\_\_\_\_

**RECENT TESTS** (lab work, x-rays, CT, MRI) \_\_\_\_\_

\_\_\_\_\_

**OTHER PROVIDERS**

\_\_\_\_\_

\_\_\_\_\_