New Patient Intake Form

Last Name:	First Name:	Middle Initial:	Date of Birth:	Age:	Circle: M or F
Insurance Contract Number:			Insurance Group Number:		
Address (Street, City, State, Zip):			Contact Phone Number:		
Email Address:	Pharmacy:		Primary Physician:		
Specialist Physician Name and Specialty:		Specialist Physician Name and Specialty:			

Past Medical History:

Please check (☑) all that apply to you:

☐ Amputation	☐ Heart Disease (CAD)	☐ Urinary frequency
☐ Anxiety/Nerves/Nervous breakdown	☐ Heart Failure (CHF)	☐ Urinary hesitancy
☐ Bladder/Kidney Infections	☐ Heart valve replacement	☐ Weakness/tired
☐ Cancer (Type: _____)	☐ High blood pressure	Other:
☐ Chest Pain (angina)	☐ High cholesterol	
☐ Chronic kidney disease	☐ High triglycerides	
☐ Depression	☐ Peripheral neuropathy	
☐ Diabetes	☐ Retinopathy	
☐ Foot Infections/Leg Sores	☐ Sexual dysfunction	
☐ Gastroparesis	☐ Stroke	
☐ Heart arrhythmias	☐ Sleep apnea	
☐ Heart Attack (MI)	☐ Thyroid disorder	

Allergies:

_____

_____

Additional health information not included above:

_____

_____

Past Surgical History/Hospitalizations:

Your Age at Time of Care:	Reason for ED Visit or Hospitalization **OR** Type of Surgery

Family History: Please check (☑) all that apply

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease (i.e. heart attack, stroke, heart failure)
- ☐ Cancer

Diabetes Medical History:

- Which form of diabetes do you have? ☐Pre-diabetes ☐ Type 1 ☐Type 2
- Year of diabetes diagnosis: _____
- Does your physician measure your HgA1c regularly? ☐Yes ☐No
  - If yes, please record the most recent HgA1c number here and when it was taken:
    _____
- Do you regularly check your blood sugar? ☐Yes ☐No
  - If yes, how often?
    _____
  - Please list an estimate of your readings within the past week:
    _____
    _____
- Have you experienced symptoms of low blood sugar (*hypoglycemia*) such as confusion, blurry vision, shakiness, and sweating? ☐Yes ☐No
  - If yes, how frequently have you experienced these symptoms within the past year and what did you do?
    _____
    _____
    _____
    _____
- Have you experienced symptoms of high blood sugar (*hyperglycemia*) such as extreme thirst, frequent urination, increased hunger, and fatigue? ☐Yes ☐No

- If yes, how frequently have you experienced these symptoms within the past year and what did you do?
  _____
  _____
  _____
  _____

- Have you had your eyes checked by a specialist in the last 12 months? ☐Yes ☐No
- Have you had a foot exam in the last 12 months by a doctor or podiatrist? ☐Yes ☐No
- Have you had your kidneys checked by your doctor in the last 12 months? ☐Yes ☐No

<u>Social History</u>:

***Caffeine*:**

- Do you drink caffeine? ☐Yes ☐No
- If so, please describe the drink type and how many servings of caffeinated foods or beverages you ingest everyday on average: _____
  _____

***Tobacco*:**

- Do you currently or have you ever used tobacco products? ☐Yes ☐No
- If yes, what type of tobacco? _____
- How long have you or did you use these products? _____
- How much did you or do you use per day on average? _____

***Alcohol*:**

- Do you consume alcoholic beverages? ☐Yes ☐No
- If yes, please describe the drink type and frequency with which you drink alcohol:
  _____
- Do you have a history of alcohol abuse? ☐Yes ☐No

***Drugs*:**

- Do you use recreational drugs (marijuana, cocaine, etc.)? ☐Yes ☐No
- If so, what type? _____

***Exercise*:**

- Do you exercise regularly? ☐Yes ☐No
- If so, please describe the type of physical activity and frequency with which you exercise weekly:_____
  _____
- Do you have any medical conditions that limit your physical activity? ☐Yes ☐No
  - Please describe:_____
    _____

***Diet*:**

- Do you follow any special or restrictive diets (i.e. low-salt, low-fat, low-carb, diabetic, high protein, etc.)? ☐Yes ☐No
- If yes, please describe:_____
  _____
  _____

Current Medications:
Please list below all of the medications you are currently taking:

Medication Name:	**Dose:** (mg, units, etc)	**How do you take it?**	**Start Date:**	**What is it for?**

- Please list any herbal remedies, OTC products, or vitamins that you take below:
_____
_____
_____
- Have you taken any steroids (eg. prednisone) that impacted your diabetes? ☐Yes ☐No
    - How did it impact your diabetes?_____

Vaccination History:
- When did you last receive a flu shot? _____
- When was your last pneumonia vaccine (*Pneumovax and/or Prevnar*)?_____
- Have you received the shingles vaccine (*Zostavax and/or Shingrix*)? ☐Yes ☐No
    - If yes, when did you receive it? _____
- When was your last tetanus (Td) or Tdap (whooping cough) vaccine?_____

<u>Social Factors</u>:

***Family Environment and Support*:**

- Do you live alone? ☐Yes ☐No
  - If no, how many people live with you: _____
- Do you prepare your own meals? ☐Yes ☐No
  - If no, who? _____
    _____
- Do you have support from family or others to help manage your diabetes? ☐Yes ☐No
- Who helps you the most in caring for your diabetes?

☐ Spouse	☐ Healthcare professional
☐ Other family members	☐ Community health worker
☐ Friends	☐ Case manager/social worker
☐ Paid helper	☐ Other (specify): _____
☐ Home Nurse	☐ No one/self

- How often do you need to have someone help you when you read instructions, pamphlets, or other written health materials from your doctor or pharmacy?
  ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

***Cultural Factors*:**

- Is there anything specific to your culture that you think influences your ability to manage your diabetes? ☐Yes ☐No
  Please describe: _____
  _____
  _____
- Do your cultural beliefs influence your ability to manage your diabetes? ☐Yes ☐No
  Please describe: _____
  _____
  _____
- Are there certain types of foods important to your culture? ☐Yes ☐No
  Please describe: _____
  _____
  _____
- Are there any religious or cultural factors that affect how you eat? ☐Yes ☐No
  Please describe: _____
  _____
  _____
- List any other cultural factors that impact the management of your diabetes:
  _____
  _____
  _____

Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

<u>Individual Educational Plan</u>:

- Would you like help with any of the following (check (☑) all that apply):
  - ☐ Eating healthier meals/following a healthier meal plan
  - ☐ Increase my level of physical activity/exercise
  - ☐ Increase frequency of my blood sugar monitoring
  - ☐ Increase support from family or friends
  - ☐ Set achievable weight loss goals
  - ☐ Increase my understanding of diabetes
  - ☐ Increase my understanding of my diabetes medication(s)
  - ☐ Improve my ability to manage stress and/or emotions that affect my diabetes
  - ☐ Increase my ability to better manage complications associated with diabetes (eg. neuropathy/nerve pain, vision problems, kidney problems, low blood sugar)
  - ☐ Increase my ability to use the medical system more effectively (ie. better communication with doctors)
  - ☐ Increase my ability to appropriately take my medications
  - ☐ Increase my ability to give myself injections at appropriate/regular time

- Identify the top three problems or issues which impact your ability to managing your diabetes:
  1. _____
  2. _____
  3. _____

- Identify barriers to managing your diabetes successfully:

  _____
  _____
  _____
  _____