

Palm Beach Diabetes & Endocrine Specialist, P.A.

(Please fill out completely)

Name: _____ Date of Birth: _____ Age: _____

Female: _____ Male: _____ African American/Black _____ Alaskan/Native American _____

Asian/Pacific Islander _____ Hispanic/Latin American _____ Caucasian/White _____

Phone number (H) _____ (W) _____ Other: _____

Address: _____

What YEAR were you first told you had diabetes? _____ Type 1 _____ Type 2 _____ Unsure _____

Recent Hemoglobin A1c% _____ Is your diabetes treated with Diet? Y N Pills? Y N Exercise Y N

Past or current employment _____ Are you retired? _____

Are you: Single _____ Married _____ Divorced _____ Widowed _____

Who is your primary support person? (Spouse, friend, relative) Name: _____

Current major stress? _____

What do you do to cope with stress? _____

Number of years of school completed? High school _____ College _____ Other _____

How would you rate your health? Excellent _____ Good _____ Fair _____ Poor _____

Have you attended diabetes education? Y N If YES Where/When _____

How do you feel about having diabetes? _____

Do you read and speak English? Y N Spanish Y N Other _____

Do you follow a special diet? Y N What kind? _____

Do you skip meals? Never _____ Occasionally _____ Frequently _____ Always _____

Are your meal times consistent: _____ Drink Alcohol? _____ How often? _____

Present weight? _____ Ibs. Height: _____ ft. _____ in. Desired weight: _____ Ibs.

Lowest weight: _____ Ibs. Highest weight _____ Ibs,

List any special dietary needs (allergies, likes, dislikes, Religious) _____

Religious observances: _____ Favorite restaurant _____

How many times each week are eaten from a restaurant? _____

What diabetes medications are you taking? _____

Do you take them: Before meals? Y N During meals? Y N or After meals? Y N

If on Insulin, where do you inject? _____

Where do you store your insulin? Refrigerator _____ Room Temperature _____

Do you test your blood sugars: Y N If yes, How often do you test your blood sugars? _____

Do you test 2 hours after a meal: Y N What type of meter do you have? _____

List below what you ate yesterday, your blood glucose and medications.

Breakfast	Lunch	Dinner	Snacks
Blood Glucose:	Blood Glucose:	Blood Glucose:	Blood Glucose:
Food:	Food:	Food:	Food:
Medication:	Medication:	Medication:	Medication:

Do you exercise? Y N If yes, What type of exercise? _____
 What days: _____ How many minutes? _____

In the past 12 months, have you been hospitalized? Y N Date: _____ Diagnosis: _____
 Any Emergency Room visits? Y N Reason: _____

Wellness

Name of your podiatrist: _____
 Do you inspect your feet? Y N If YES, how often? _____
 Do you walk barefoot? Y N Do you have any open sores on your feet? _____
 History of Amputations? Y N How often do you see the podiatrist? _____
 Do you have any numbness, tingling, burning or pain in your hands or lower legs? Y N
 Have you been diagnosed with Neuropathy? Y N
 Have you been diagnosed with delayed stomach emptying (gastroparesis) Y N
 MEN only: Have you been diagnosed with erectile dysfunction? Y N

Name of your ophthalmologist: _____ Last visit? _____
 Any diabetes eye problems? Y N If Yes, explain _____
 Previous laser therapy? Y N If YES, When? _____

Name of your Dentist: _____ Last visit? _____
 How often do you see your Dentist? _____ Any dental problems? _____

Name of your Cardiologist: _____
 Do you have poor circulation? Y N If YES, Where? _____ Total Cholesterol _____
 LDL _____ HDL _____ Triglycerides _____ Blood Pressure _____
 Do you smoke? Y N If YES, How long? _____ Packs/day _____
 Bypass surgery? Y N If YES, When: _____ Heart attack? Y N If YES, When: _____
 Stroke? Y N If YES, When: _____