NEW PATIENT CONSULTATION FORM

Confidentiality Notice: Please note that this form is part of the confidential medical record and will be kept in your Diabetes Relief file. Information contained here will not be released to any person except under your authorization.

Name: ______________________________________ Preferred Name: ____________________
Date of Birth: _____________________________________
In brief, what main concern(s) and/or interest(s) bring you to our office? ______________________
____

SOCIAL HISTORY

Marital Status (*circle one*): Single Married Divorced Widowed

Number of children: _____ **Race or Ethnicity**: _____________

Females (*circle*): Are you Pregnant? Nursing? Planning pregnancy?

Date of Last Menstrual Period: _____________

Occupation (if retired, previous occupation): ____

Smoking
Have you ever smoked? (*circle*): Yes No
If Yes, what age did you start? _______ How many cigarettes per day? _______
Have you tried to quit? _______ If successful, what age did you quit? _______

Alcohol
Do you drink any alcohol? (*circle*): Yes No
If Yes, how much (# of drinks per day, month, or year)? ____________________
If so, what type of alcohol? (*circle all that apply*): Wine Beer Liquor

Recreational Drugs
Have you ever used recreational drugs? (*circle*): Yes No
If Yes, which ones & when was the last date of use? ____________________

MEDICAL HISTORY

Allergies (list any allergy to drug, latex, and/or food): ____

Medications (list all medications--with dosages--you regularly take, including over-the-counter, herbal, and natural remedies. If you are on **insulin**, please clarify administration method, whether vials, pens, or pump):

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Medical Conditions:
Please ***circle*** diagnosed medical conditions, write date of each diagnosis, and if applicable include further details.

Diagnosis	Date of Diagnosis	Details
Diabetes *Circle one*: Type 1 Type 2 Gestational Unknown		
Pre-Diabetes		
High Blood Pressure		
High Cholesterol		
Heart Murmur		
Heart Attack(s)		
Stroke(s)		
Thyroid Disorder *Circle*: Hyperthyroidism Hypothyroidism Thyroid nodule(s) Other		
Liver Disease *Circle:* Hepatitis Fatty Liver Other		
Kidney Issues *Circle:* Kidney Stones Chronic Kidney Disease On Dialysis Other		
Gastrointestinal Problems *Circle:* Gastroparesis Acid Reflux Diverticulitis Other		
Eye Disease *Circle:* Cataracts Glaucoma Retinopathy Other		
Reproductive Issues *Circle:* Erectile Dysfunction Prostate Enlargement Infertility Other		
Vitamin Deficiencies *Circle:* Low Vitamin D Low Vitamin B12 Low Magnesium Other		

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Psychological Diagnosis *Circle:* Depression Anxiety Bipolar Disorder Other		
Anemia *Specify type if known:*		
Cancer *Specify type if known:*		
Other Conditions: ________________________ ________________________ ________________________		

Surgical History:
Please list prior surgeries and an accompanying date or year, if known.

______________________________ ____
______________________________ ____
______________________________ ____
______________________________ ____
______________________________ ____

Family History:
Please list family health information if known, with emphasis on significant, chronic conditions.

Family Member	**If deceased, age at death**	**Significant Health Issues** (especially any diabetes, heart disease, stroke, cancer)
Father		
Mother		
Brother(s)		
Sister(s)		
Grandparent(s)		

Diabetes-specific Health Information:
Free text or circle your answers as designated. For some, note that **Y** indicates “Yes” & **N** indicates “No.”

1) What was your most recent HgbA1c? __________%
2) Have you been hospitalized in the last 12 months related to diabetes (*circle*)? **Y** **N**

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3) Do you have any of the following diabetes-related complications? (*circle*- a, b, c)
    a. Neuropathy (nerve damage). If yes, do you clarify symptoms/diagnosis:
        i. When were you diagnosed? _______________
        ii. Numbness/tingling in hands? **Y N**
        iii. Numbness/tingling in feet? **Y N**
        iv. Pain in hands? **Y N**
        v. Pain in feet? **Y N**
    b. Retinopathy (bleeding behind your eyes)
        i. When was your last eye exam? _______________
        ii. Do you wear (*circle*) glasses? __________ contacts? __________
        iii. Have you received any eye injections? **Y N** When? __________
    c. Kidney dysfunction
        i. Have you ever been referred to a kidney doctor? **Y N**
        ii. Are you on (*circle*) hemodialysis? peritoneal dialysis?
        iii.
4) How often do you check your blood sugar? ___________________________________
    a. How often is your have blood sugar below 80 mg/dL? _________________________
    b. If known, what does your blood sugar range at the following times?
        i. on fasting (8 hours without eating)? _______________
        ii. two hours after your largest carbohydrate meal? _______________
        iii. at bedtime? _______________
5) How many meals do you eat per day? __________ Do you snack at bedtime? **Y N**
6) Have you seen a dietician? **Y N**
7) Do you count carbohydrates? **Y N**
    a. If so, how many carbohydrates do you currently eat per day? __________ grams
8) Do you exercise? **Y N**
    a. If so, how many minutes per week on average? __________
    b. What type (e.g. yoga, weights, running, walking)? ________________________

SYMPTOM REVIEW

Please check current issues and symptoms, if a chronic concern or a recent significant change.

Constitutional:

- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats
- ☐ Sleep disruption
- ☐ Recent, significant weight change

Eyes and Ears:

- ☐ Wear glasses
- ☐ Wear contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Photophobia
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Ear pain
- ☐ Hearing loss

Nose:

- ☐ Allergy or sinus problems
- ☐ Nosebleeds
- ☐ Nasal congestion
- ☐ Nasal discharge

Mouth and throat:

- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or taste

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- ☐ Sore throat
- ☐ Voice change
- ☐ Current, untreated dental problems
- ☐ Trouble swallowing

Cardiovascular:

- ☐ Chest pain
- ☐ Chest pressure
- ☐ Chest tightness
- ☐ Palpitations
- ☐ Dizziness

Respiratory:

- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Heartburn
- ☐ Change in usual bowel pattern
- ☐ Blood in stool or vomit

Genitourinary:

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Straining to urinate
- ☐ Increased frequency of urination
- ☐ Nighttime urination
- ☐ Leaking urine
- ☐ Sexual dysfunction

Musculoskeletal:

- ☐ Joint pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Stiff joints
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Difficulty walking

Skin:

- ☐ Rashes
- ☐ Changes in skin color
- ☐ Change in hair or nails
- ☐ Leg swelling
- ☐ New lesion(s)

Neurological:

- ☐ Numbness
- ☐ Tingling sensation
- ☐ Complete loss of sensation
- ☐ Loss of balance
- ☐ Paralysis
- ☐ Frequent or severe headaches
- ☐ Convulsions or seizures
- ☐ Tremor

Psychosocial:

- ☐ Depression
- ☐ Memory loss
- ☐ Confusion
- ☐ Anxiety
- ☐ Suicidal thoughts

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Hematologic / Lymphatic:

- ☐ Trouble healing after cuts
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Swollen lymph nodes

Endocrine:

- ☐ Heat intolerance ☐ Cold intolerance ☐ Excessive thirst

Other Comments:

____

Patient Signature: ______________________________ Date: ____________________

Reviewed By: __________________________________ Date: ____________________

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Hormone & Diabetic Infusion
CENTER
of Lake Oconee

MEDICAL RECORDS RELEASE FORM

Patient's Name: ____

Social Security #:____

Date of Birth:____

Please release my medical records from the following physician(s):

Name:____

Address:_______________________________________

City, State, Zip:__________________________________

Phone #:_______________________________________

Fax #:____

The release of my records is for continuation of care. This document is to expire six (6) months from date of signature.

Physician's Signature_____________________________Date________________

Patient's Signature_______________________________ Date________________

Hormone & Diabetic Infusion CENTER of Lake Oconee

Patient Name: ______________________________

DOB: _______________ Date of Visit: ______________

VF-14 QOL Questionnaire

Because of your vision, how much difficulty do you have with the following activities? Check the box that best describes how much difficulty you have, even with glasses.
If you do not perform the activity for reasons unrelated to your vision, circle "n/a"

Activity		None	A little	Moderate	Great deal	Unable to do
1. Reading small print, such as medicine bottle labels, a telephone book, or food labels	n/a	☐	☐	☐	☐	☐
2. Reading a newspaper or a book	n/a	☐	☐	☐	☐	☐
3. Reading a large-print book or large-print newspaper or numbers on a telephone	n/a	☐	☐	☐	☐	☐
4. Recognizing people when they are close to you	n/a	☐	☐	☐	☐	☐
5. Seeing steps, stairs or curbs	n/a	☐	☐	☐	☐	☐
6. Reading traffic signs, street signs or store signs	n/a	☐	☐	☐	☐	☐
7. Doing fine handwork like sewing, knitting, crocheting, carpentry	n/a	☐	☐	☐	☐	☐
8. Writing checks or filling out forms	n/a	☐	☐	☐	☐	☐
9. Playing games such as bingo, dominos, card games, or mahjong	n/a	☐	☐	☐	☐	☐
10. Taking part in sports like bowling, handball, tennis, golf	n/a	☐	☐	☐	☐	☐
11. Cooking	n/a	☐	☐	☐	☐	☐
12. Watching television	n/a	☐	☐	☐	☐	☐
13. Driving during the day	n/a	☐	☐	☐	☐	☐
14. Driving at night	n/a	☐	☐	☐	☐	☐

Patient Signature: ____

Office use only:	**(C)** *# checked boxes in column*					
	(F) *factored amounts*	X4 =	X3 =	X2 =	X1 =	**0**

C = total number of **C**hecked boxes in column

F = sum of the **F**actored amounts

V =Final **V**-14 score

Final Score: (F _____ / C _____) x 25 = V

V = ☐

MD Signature: ________________________

Hormone & Diabetic Infusion CENTER of Lake Oconee

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ DATE: ____________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____ +	____ +	____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ____________

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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