GUPTA MEDICAL SPECIALISTS

NEW PATIENT INFORMATION FORM -*DIABETES*

Please print all information. Thank you for your cooperation.

Patient Name: ____

Date of Birth: ____________________ Social Security #______________________

Address: ____

City: ____

State: ____________________ Zip Code:______________________

Phone (home):____________________ Work/Cell: ______________________

Employer: ____

Marital Status: Single Married Divorced Widowed

Email Address: ____

Is it ok to mail correspondence such as reminders and letters to you? _____Yes _____No

Referring Physician or Referral Source:

____

Primary Care Physician:

____

Do you want your medical records sent to this practice? ____Yes ____No

Insurance Plan: ____

Group Number: ____________________ Policy Number: ______________________

Issue Date: ____________________

Secondary Insurance Plan: ____

Group Number: ____________________ Policy Number: ______________________

Issue Date: ____________________

Thank you for taking the time to complete our intake forms. Please sign & date (below)

______________________________ ______________

Patient's Signature Today's Date

HISTORY OF PRESENT ILLNESS

1. Age:________ Male Female Diabetes: Type I Type II
2. When were you diagnosed with diabetes? ________________________________
3. How were you diagnosed? ________________________________
4. Have you ever been hospitalized for diabetes? No Yes If yes, where and when (diabetic ketoacidosis, hyperosmolar state)
   ____
   ____
5. What type of glucometer do you use? ________________________________
6. How many times a day do you check your sugar? ________________________________
7. How many meals a day do you eat? ________________ How many snacks? ________________
8. What are you average sugars at:

   Breakfast: __________ Lunch: __________ Dinner:__________ Bedtime: ____________
9. Have you ever had a hypoglycemic(low sugar level) episode requiring assistance from another person to recover? ________________________________
10. How many times do you urinate at night? ________________________________
11. Do you exercise and if so for how many minutes and how many days a week?
    ____
    ____
12. What is the most you have weighed? ____________________
13. What do you think your ideal weight is ________________
14. When was your last appointment with the eye doctor? ________________________________
    Do you have any evidence of diabetes in your eyes (retinopathy)? ________________________________
15. Do you have tingling and numbness in your feet (diabetic neuropathy)? ________________________________

Past Medical History:

No Medical History	COPD	Kidney Disease	Seizures
Please circle all that apply	Emphysema	Stroke/CVA	Osteoarthritis
Hypertension	Obstructive Sleep Apnea	Headaches/Migraines	Rheumatoid Arthritis
Congestive Heart Failure	Hepatitis	Anemia	Gout
Abnormal Heart Rhythm	Diabetes Type 1 2	Lupus	Endometriosis
Heart Disease, CAD	Hypothyroidism	Reflux	Cancer (specify type)
Peripheral Vascular Dz	Hyperthyroidism	Irritable Bowel	
Blood Clots /DVT	Enlarged Prostate/BPH	Anxiety	Other ________________________
High Cholesterol	Osteoporosis	Depression	

Past Surgical History:

No Surgical History	Tonsil	Eye	Hip Replacement
Please circle all that apply	Thyroid	Ear	Knee Surgery
Heart Bypass	Appendix	Prostate	Neck Surgery- Fusion
Heart Pacemaker	Gallbladder	Kidney	Back Surgery-Fusion
Angioplasty Stent	Gastric Bypass	Bladder	Other ________________________
Brain	Hysterectomy	Hernia	
Lung	C-Section	Shoulder – Rotator Cuff	

Family History:

Relative	***Age/Living***	***Health Problems***
Father		
Mother		
Brother		
Sister		

Allergies (to medications and food)

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Medications:

(please include all herbal supplements and/or vitamins)

SOCIAL HISTORY

1. Current work status________________________________ Occupation: ____
2. Marital Status: Single Married Divorced Widowed
3. Number of Children: ____
4. I live: Alone With: ____________________ I live in a: House Apartment Nursing Facility
5. Are you a cigarette smoker? No Yes How old were you when you began smoking? __________________
   How much do you smoke daily? ________________ When did you quit smoking? _________________________
6. Do you drink any alcoholic beverages: (check one) No Yes
   1 2 3 4 5 6 drinks daily weekly monthly social use only
7. Have you ever had a problem with drug dependence? Yes No
8. Please write any additional information that you feel is important for us to know.

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REVIEW OF SYTEMS

Do you currently have any of the following medical symptoms?

General
- ○ Unexplained weight loss
- ○ Appetite change
- ○ Fevers or chills
- ○ Night sweats
- ○ Marked fatigue
- ○ Difficulty sleeping

Eyes
- ○ Glasses
- ○ Change in vision
- ○ Double vision

Ear, Nose, Throat
- ○ Difficulty swallowing
- ○ Hoarseness
- ○ Loss of hearing
- ○ Ear pain
- ○ Nosebleeds

Cardiovascular
- ○ Heart or chest pain
- ○ Abnormal heartbeat
- ○ Leg swelling

Respiratory
- ○ Morning cough
- ○ Shortness of breath
- ○ Productive cough or sputum

Digestive
- ○ Nausea or vomiting
- ○ Stomach pain or ulcers
- ○ Heart burn
- ○ Diarrhea
- ○ Constipation
- ○ Uncontrolled loss of stool
- ○ Blood in stools

Skin
- ○ Rashes
- ○ Itchiness
- ○ Easy bruising

Neurological
- ○ Seizures
- ○ Blackouts/fainting
- ○ Headaches/migraines

Musculoskeletal
- ○ Joint pains
- ○ Joint swelling
- ○ Numbness in feet/hands
- ○ Muscle weakness

Genitourinary
- ○ Burning on urination
- ○ Incontinence
- ○ Pelvic pain
- ○ Impotence
- ○ Abnormal Bleeding

Psychiatric
- ○ Depression
- ○ Anxiety
- ○ Paranoia

Other

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