Established Patient - Diabetes

CLINICAL INTAKE SHEET PATIENT NAME: ___________________________ DOB: ____________

Please complete the below questions to the best of your ability.
*****We ask all patients 10 years or older to try to complete as many questions as possible without help from parents.***

The patient is diagnosed with: ☐ Type 1 ☐ Type 2 ☐ Other: _____________
What date was the patient diagnosed? _________________ (mm/dd/yyyy)
Who is with the patient for the visit today?_____________________________
Date of last eye exam: ___________ _Date of last dentist visit: _____________
How many school/work days has the patient missed since the last visit? __________
Has the patient been hospitalized or in the emergency room since your last visit?
☐ Yes ☐ No Date: __________ For: __________________________

Insulin Information:
Do you feel different when your blood sugar is low?
☐ Never ☐ Sometimes ☐ Always
Since your last visit, have you had a seizure or been unconscious because of low blood sugar? ☐ Yes ☐ No
Do you check for ketones? ☐ Yes ☐ No
If yes, when do you check? ___________________________________
Do you use insulin: ☐ syringes ☐ pens ☐ pump
Check which insulin you use: ☐ Lantus ☐ Levemir
☐ Humalog ☐ Novolog ☐ Apidra ☐ NPH ☐ Other:________________
Do you take your insulin before you start eating? ☐ Yes ☐ No
If you are not using an insulin pump, what are your insulin doses?
Long acting insulin (Lantus/Levemir): _______________________________
Food dose to cover carbs: ___________________________________
Corrective dose for high blood sugar: ________________________________
Ketone correction: _______________________________________

Does the patient check their own blood sugar? ☐ Yes ☐ No
Does the patient give their own insulin injections? ☐ Yes ☐ No
Does the patient carry glucagon? ☐ Yes ☐ No Expiration: _________
Does the patient wear a medical alert? ☐ Yes ☐ No
What kind of special diet does the patient follow? _________________ _______

Ages 10 and over only (this section)

Over the past two weeks, how often have you been bothered by the below problems?	***Not At all***	***Several days***	***More than half the days***	***Nearly every day***
Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*
Feeling nervous, anxious, or on edge	*0*	*1*	*2*	*3*
Not being able to stop or control worrying	*0*	*1*	*2*	*3*

Provider/Team Notes Only

Age: ______ years ______ months
Last Visit:

Date________ with _______________

Height _______ in _______ cm
Weight _______ lbs _______kg
HgbA1C_______
AvgBG _______

Patient Portal?
Vitals:
Height ________ in _______cm
Weight ________lbs ______kg
BP ____________ P _______
Head Circum __________
HgbA1C _______
Avg BG_______

Attach U/A (if applicable):

Total ______

Total ______

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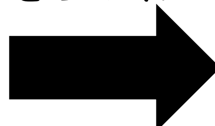

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PEDIATRIC ENDOCRINOLOGY
Wendy L. Novak Diabetes Care Center

Please complete the below questions to the best of your ability.

Review of Systems:

Please √ check all symptoms below that the patient is currently experiencing:

☐ Fever	☐ Fatigue	☐ Recent Weight Loss	☐ Recent Weight Gain
☐ Eye Pain	☐ Eye Redness	☐ Vision Problems	☐ Wears Contacts/Glasses
☐ Earache	☐ Sore Throat	☐ Difficulty Swallowing	☐ Hoarseness
☐ Nosebleeds	☐ Freq. Ear Infections	☐ Trouble Hearing	☐ Poor Sense of Smell
☐ Chest Pain	☐ Heart Beats Too Fast	☐ Heart Beats Too Slow	☐ Palpitations
	☐ High Blood Pressure	☐ Sleep Problems	
☐ Cough	☐ Shortness of Breath	☐ Wheezing	☐ Snoring
☐ Constipation	☐ Diarrhea	☐ Nausea	☐ Vomiting
☐ Stomach Pain	☐ Heartburn	☐ Poor Appetite	
☐ Joint Pain	☐ Joint Swelling	☐ Joint Stiffness	☐ Limb Pain
☐ Eczema	☐ Dry Skin	☐ Acne	☐ Rash
☐ Thinning Hair	☐ Excess Hair Growth	☐ Early or Late Puberty	☐ Cold/Heat Intolerance
☐ Painful Periods	☐ Irregular Periods	☐ **Date of Last Period:** ____	☐ Growth Concerns
☐ Bedwetting	☐ Excessive Thirst	☐ Excessive Urination	
	☐ Behavior Problems	☐ Receives Therapy	☐ Special Learning Needs
☐ Bruises Easily	☐ Bleeds Easily	☐ Anemia	
☐ Seizures	☐ Dizziness	☐ Headache/Migraine	

Medications:

Are you taking medications other than insulin? ☐ Yes ☐ No

If so, please list them.

Med: ______________________ Dose: __________ # Times Daily: ______

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Allergies:

Please list all environmental, food, and medication allergies.

____

Past Medical History:

Any changes to the patient's current medical problems? ☐ Yes ☐ No

If yes, please list: ____

Has the patient received a flu vaccine in the last year?

☐ Yes ☐ No, but will ☐ No, will not

Surgical History:

Any recent surgeries? ☐ Yes ☐ No

If yes, please list: ____

Family History:

Any changes to the patient's family medical history? ☐ Yes ☐ No

If yes, please list: ____

Social History:

What grade is the patient in at school? _______ School: ___________________

How well is the patient doing in school? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any activities or sports? (please list) ________________________________

Any family stressors? ____

Any changes to the patient's social history? ☐ Yes ☐ No

If yes, please list: ____

Provider/Team Notes Only

Recent Labs/Xrays?

Refills Needed?

Medication Allergies?

Flu Shot?

Does the patient smoke?

Has the patient ever smoked?