DIABETES & ENDOCRINE WELLNESS CENTER, LLC

(Please select **ALL** you have experienced since your last visit) **(DM Form)**

PATIENT NAME: _____**DOB:**_____**DATE OF VISIT:** _____

GENERAL

Weakness	☐ YES	☐ NO
Hair loss	☐ YES	☐ NO
Headache	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight gain	☐ YES	☐ NO
Weight loss	☐ YES	☐ NO
Fatigue	☐ YES	☐ NO
Loss of appetite	☐ YES	☐ NO
Difficulty with sleep	☐ YES	☐ NO

EYES

Cataracts	☐ YES	☐ NO
Bulging eyes	☐ YES	☐ NO
Laser treatment	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Blurry Vision	☐ YES	☐ NO
Loss of Vision	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO

ENT/THYROID

Change of voice	☐ YES	☐ NO
Difficulty in swallowing	☐ YES	☐ NO
Swelling in the neck	☐ YES	☐ NO

ENDOCRINE

Frequent urination at night	☐ YES	☐ NO
Cold intolerance	☐ YES	☐ NO
Breast discharge	☐ YES	☐ NO
Increase in size of hands or feet	☐ YES	☐ NO
Excessive thirst	☐ YES	☐ NO
Heat intolerance	☐ YES	☐ NO

RESPIRATORY

Cough	☐ YES	☐ NO
Shortness of breath	☐ YES	☐ NO

GI SYSTEM

Stomach pain	☐ YES	☐ NO
Constipation	☐ YES	☐ NO
Diarrhea	☐ YES	☐ NO
Nausea	☐ YES	☐ NO
Vomiting	☐ YES	☐ NO

CARDIOVASCULAR

Chest pain	☐ YES	☐ NO
Palpitations	☐ YES	☐ NO

BLOOD

Heavy period	☐ YES	☐ NO
Easy bruising	☐ YES	☐ NO

GENITOURINARY

Decreased sexual desire	☐ YES	☐ NO
Men: Erectile dysfunction	☐ YES	☐ NO
Women: Absent periods	☐ YES	☐ NO

Date of Last menstrual period _____

MUSCULOSKELETAL

Fractures as an adult	☐ YES	☐ NO
Muscle weakness	☐ YES	☐ NO

SKIN/NAILS

Brittle nails	☐ YES	☐ NO
Dry Skin	☐ YES	☐ NO

NEUROLOGIC

Burning	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tingling	☐ YES	☐ NO

PSYCHIATRIC

Anxiety	☐ YES	☐ NO
Depression	☐ YES	☐ NO

Medical Questions

I take a daily aspirin	☐ YES	☐ NO
I have eye problems from my diabetes	☐ YES	☐ NO
I have kidney problems from my diabetes	☐ YES	☐ NO
I have numbness/tingling/burning in my feet	☐ YES	☐ NO

I exercise _____ number of times a week by
Elliptical Gardening Jog Treadmill Water Sports
Walk Yoga Other _____

SCREENING (GIVE DATES OF LAST EXAM)

My last PSA was in the last 12 months(MEN)	☐ YES	☐ NO
My last eye exam was in the last 12 months	☐ YES	☐ NO
My last foot exam was in the last 12 months	☐ YES	☐ NO

I would like to be addressed by:

☐ **My First name** ☐ **Mr. Last Name**

☐ **Mrs. Last Name** ☐ **Miss. Last Name**

☐ **Ms. Last Name** ☐ **Dr. Last Name**