**DIABETES & ENDOCRINE WELLNESS CENTER, LLC**

(Please select **ALL** you have experienced since your last visit) **(NON-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 |

**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**