



NEW CONSULTATION INFORMATION

NAME _____

DATE: _____

Reason for consultation _____

Referring Physician _____

Medical History:

- Diabetes Type _____ Heart Disease Stroke High Blood Pressure
- Peripheral Vascular Disease High Cholesterol
- Depression Anxiety Thyroid disease (type _____)
- Cancer (specify) _____
- Other (specify) _____

Surgical History and Date:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Medications (name, dose and frequency):

- | | |
|----------|-----------|
| 1. _____ | 9. _____ |
| 2. _____ | 10. _____ |
| 3. _____ | 11. _____ |
| 4. _____ | 12. _____ |
| 5. _____ | 13. _____ |
| 6. _____ | 14. _____ |
| 7. _____ | 15. _____ |
| 8. _____ | 16. _____ |

Drug Allergies and Reaction: _____

Family History:

- Diabetes Type _____ Heart Disease Stroke High Blood Pressure
- Peripheral Vascular Disease High Cholesterol
- Depression Anxiety Thyroid disease (type _____)
- Cancer (specify) _____
- Other (specify) _____

Social History:

- Marital Status: _____
- Occupation _____
- Education (specify highest level) _____
- Alcohol; if yes: number of drinks/week _____
- Tobacco; Past Current; packs per day _____ x _____ years
- Illicit drug use; if yes, specify type: _____

Review of Systems (please check)

General

- Fever Chills Night sweats Fatigue Lymph Nodes
 Appetite change Weight loss Weight gain Low blood sugar

Head/Eyes/Ears/Nose/Throat

- Headache Vision change Sore throat Double vision Snoring

Skin

- Rash Itching Color change Dryness Ulcers
 Lumps Moles Bruising Purple stretch marks Hair growth

Heart

- Chest pain Swelling Fluttering Palpitations Slow heart rate
 Fast heart rate Leg pain with walking High blood pressure

Lungs

- Pain Cough Sputum production Short of breath Blood
 Wheezing TB exposure Stridor

Gastrointestinal

- Heartburn Nausea Vomiting Fatigue Feel "full" quickly
 Diarrhea Constipation Night sweats Blood

Urinary

- Frequency Incontinence Night frequency Cloudy Discharge
 Difficulty Blood

Genital/Breast

- Impotence (males) Testicular mass Breast growth (males) Breast mass Fatigue
 Vaginal discharge (females) Menstrual irregularity (females)

Musculoskeletal

- Cramping Muscle Pain Joint pain Joint swelling Joint stiffness

Nervous

- Tremor Sweating Numbness Clumsy Falls
 Seizures Pain Weakness Stroke Low blood sugar

Psychological

- Anxiety Depression Insomnia Hallucination Difficulty concentrating

Patients with Diabetes Only

Complications (please check if present)

- Eye disease (retinopathy)
 Kidney disease (nephropathy)
 Numbness or painful feet/hands (neuropathy)
 Stroke
 Heart Attack
 Foot Ulcer or Joint Disease
 Unaware of low blood sugar
 Stomach disease (gastroparesis)

Maintenance Checkups (specify last appointment)

- Eye Exam: _____
 Dental Exam: _____
 Foot Exam: _____
 Influenza Vaccine: _____
 Pneumonia Vaccine: _____

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