NEW PATIENT HEALTH QUESTIONNAIRE: **Date of visit:_____**

Name: _____ Age: _____

What is the chief reason you are being seen for today? _____

Please list all medical problems for which you have been diagnosed or treated:

Please list any surgeries or hospitalizations (include dates, if known):

Are there any symptoms you are concerned about today? If so, please describe:

SOCIAL ISSUES: (please circle)

Do you smoke? YES, packs per day _____ age when started_____ NO

How many alcoholic drinks/ day ? 0 ½ 1 2 3 4 or more

Do you use illicit drugs? YES NO If so, what kind? _____

Marital status (optional): single married divorced/separated widowed

What is your occupation? _____

FAMILY MEDICAL HISTORY: Is there a family history (blood relatives only) of the following conditions? If so, circle and write how family member is related to you. (i.e. mother/ father, sister/ brother, grandparent, etc.)

Diabetes_____ High Blood pressure_____ High cholesterol_____

Heart Disease_____ Obesity_____ Cancer_____

Osteoporosis_____ Calcium problems_____Thyroid_____

Are there other diseases/ conditions which run in your family?_____

MEDICATIONS: (please list med name, dose and how often you take it)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES (please list, if any):

FOR DIABETES PATIENTS ONLY: (skip the rest of this form if you do not have diabetes)

How long have you had diabetes? _____

Are you diagnosed as Type 1 or Type 2? _____

How many times a day do you check your sugar?_____
What is the range of numbers you see?_____

Are you using a Continuous Glucose Sensor? _____ If so, what type? _____

Please list any diabetes meds which have been unsuccessful for you: _____

Have you ever been hospitalized for diabetes? YES NO

Have you needed help from another person to recover from a low blood sugar? YES NO

Do you have a glucagon emergency kit? YES NO

Do you have numbness, tingling or pain in your feet or legs? YES NO

Have you had a flu shot this year? YES NO

Have you ever had a vaccination for pneumonia? YES NO

Have you ever been vaccinated for COVID-19? YES NO

Have you ever been told of bleeding or diabetic changes in your eyes? YES NO

When was the last time you saw an eye doctor for a diabetes eye exam? _____

Who is your eye doctor and what town are they in? _____

Have you ever had a heart attack or been told you have coronary artery disease? YES NO

Do you have a cardiologist? YES NO If so, who is it? _____

Thank you!
Doylestown Thyroid & Endocrine Associates