VILLAGE HEALTH PARTNERS

Village Health Partners
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# Diabetes Form - Endocrinology

## IF YOU HAVE DIABETES, PLEASE COMPLETE THIS FORM AS WELL

| **Name:** (Last, First, Middle) | **Date of Birth:** |
|---|---|
| What year were you diagnosed with diabetes | |
| How old were you when you were diagnosed with diabetes | |
| Have you had any diabetes complications, like | Eye problems (diabetic retinopathy)? ☐ No ☐ Yes |
| | Nerve problems (diabetic neuropathy)? ☐ No ☐ Yes |
| | Kidney problems (diabetic neuropathy)? ☐ No ☐ Yes |
| | Heart problems, stroke, or blood vessel blockages? ☐ No ☐ Yes |
| What pills (and doses) do you take for diabetes | |
| If you are insulin what year did you start taking insulin | |
| Please list the insulin type, dose, and times of the day that you take it | |
| Glucose meter and brand name | |
| How many times a day do you check your sugars | |

| During the last month, what have your sugars been: (generally speaking)? | | | | | | |
|---|---|---|---|---|---|---|
| Fasting / pre-breakfast sugars | Lowest | | Highest | | Usual | |
| Pre-lunch sugars | Lowest | | Highest | | Usual | |
| Pre-dinner sugars | Lowest | | Highest | | Usual | |
| Bedtime sugars | Lowest | | Highest | | Usual | |

| Diet History: | Breakfast: ____<br>Lunch: ____<br>Dinner: ____<br>Snacks: ____ |
|---|---|
| Are you on an insulin pump? If yes, add pump details: | Brand of pump:____<br>Date started: ____<br>Basal Insulin Rates: ____<br>Insulin/Carb Ration: ____<br>Insulin Correction Factor: ____ |
| Do you use a continuous glucose monitor (CGM)? | ☐ No ☐ Yes<br>If yes, brand: ____ |
| Labs: | Last hemoglobin A1c values: ____<br>Last microalbumin: ____ Result: ☐ Normal ☐ Abnormal<br>Last cholesterol test: ____ |

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| | | |
|---|---|---|
| **PNEUMONIA VACCINE:** | What year did you get your last pneumonia vaccine? | |
| | If you have **not** had a pneumonia vaccination: The Centers for Disease Control (CDC) recommends that all people with diabetes receive a pneumonia vaccination to reduce your chance of getting a bacterial pneumonia infection. It protects against 23 types of pneumococcal bacteria. It is recommended once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccine. | Do you want a pneumonia vaccination during your initial clinic visit? ☐ No ☐ Yes |

| | | |
|---|---|---|
| **FLU SHOT:** | Have you had a flu shot during this flu season (between October and February)? If so, in what month and year did you have it? | |
| | If you have **not** had a flu shot: A yearly flu shot is recommended to people with diabetes. Side effects include redness or pain at the site of injection and some people develop fevers and muscle aches. Severe allergic reactions have been reported rarely. DO NOT TAKE THE FLU SHOT IF YOU ARE ALLERGIC TO EGGS. | Do you want a flu shot during your initial clinic visit? ☐ No ☐ Yes |
| **CHOLESTEROL:** | The American Diabetes Association recommends that people over the age of 40 with diabetes take a cholesterol medicine, no matter what your cholesterol. They are known to prevent heart disease. Are you taking cholesterol medicine? | ☐ No ☐ Yes |
| **EYE EXAM:** | It is recommended that all people with diabetes have a yearly eye exam. When was your last eye exam? (month/year) | |

- **Please bring your BLOOD GLUCOSE METER and your GLUCOSE LOG to your visit.**
- **For the week prior to your visit, we request that you check your sugars 4 times a day (before each meal and bedtime) and bring these numbers written down to your appointment.**
- **Please bring all of your medications with you to your visit.**
- **Please fax these forms to 972.867.8163 prior to your visit, or come 15 minutes prior to your appointment.**

**I AFFIRM THAT THE INFORMATION REGARDING MY HEALTH PROVIDED IN THIS FORM IS CORRECT TO THE BEST OF MY KNOWLEDGE.**

Signature of Patient: ____________________________________________ Date: ________________________

**OR:**

Signature of Authorized Representative: ___________________________________ Date: __________________

Please print representative's name: ______________________________________________________________

Relationship to patient: ________________________________________________________________________