DIABETES AND ENDOCRINOLOGY ASSOCIATES, P.C.

Review of Systems
Past, Family, Social History
Treatment Questionnaire

Patient Identification Sticker

Today's Date:

Please indicate if you are currently experiencing any of these symptoms on a persistent or frequently recurring basis. Ignore the gray column. This will be completed by your healthcare provider.

Addressed by Provider	Yes	No	
			Constitutional
			poor general health recently
			recent weight change, loss of appetite
			fever, chills, profuse sweating
			fatigue, lethargy, malaise
			Eyes
			recent eye disease, injury or surgery
			blurred vision, double vision, loss of vision
			pain in the eyes
			eye examination within the last year
			Ears, Nose, Mouth, Throat
			hearing loss or ringing in the ears
			ear pain or discharge
			chronic or recurring sinus problems
			chronic or recurring sores in the nose or mouth
			chronic or recurring dental problems
			chronic or recurring sore throat
			Cardiovascular
			chest pain
			rapid or irregular heartbeat, palpitations
			sudden loss of consciousness, fainting
			shortness of breath with exertion
			swelling of the feet, ankles or hands
			Respiratory
			chronic coughing
			coughing up blood
			chronic wheezing, asthma
			chronic shortness of breath
			Gastrointestinal
			recurring nausea and vomiting, vomiting blood
			abdominal pain
			chronic or recurring diarrhea or constipation
			bloody bowel movements
			jaundice, liver disease
			Genitourinary
			frequent or painful urination
			blood in the urine
			urinary incontinence
			loss of sexual desire or sexual dysfunction
			irregular or painful menstrual periods

Addressed by Provider	Yes	No	
			Musculoskeletal
			joint pain, stiffness or swelling
			muscle pain, weakness or cramping
			limitation of motion, difficulty walking
			chronic neck or back pain
			chronic foot pain or deformity
			Skin and Breasts
			chronic or recurring rashes or sores
			suspicious moles or skin lesions
			hair loss, change in nails
			breast pain, breast lump or nipple discharge
			Neurologic
			frequent or recurring headaches
			dizziness, lightheadedness
			seizures or convulsions
			loss of sensation or muscle strength
			stroke or head injury
			memory loss, confusion
			tremor
			Psychiatric
			nervousness or anxiety
			chronic depression
			inability to concentrate
			sleep problems
			Endocrine
			excessive thirst or urination
			heat or cold intolerance
			unexplained change in skin pigmentation
			change in hat or ring size
			loss of height
			unexplained bone fractures
			Hematologic / Lymphatic
			recurring nosebleeds, bleeding gums, bruising
			chronic anemia, recent transfusion
			swollen lymph nodes
			recurring infections
			Allergic / Immunologic
			hay fever
			recurring hives
			history of HIV or AIDS

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Please help us help you by providing the following information. Patients who do not have diabetes may ignore the Diabetes Self-Management Questionaire.

Addressed by Provider	Yes	No	
			Past Medical History
☐	☐	☐	diabetes, gestational diabetes, high blood sugar
☐	☐	☐	hypertension, high blood pressure
☐	☐	☐	hyperlipidemia, high cholesterol or triglyceride
☐	☐	☐	cardiovascular (heart or blood vessel) disease
☐	☐	☐	stroke or TIA
☐	☐	☐	thyroid disease
☐	☐	☐	parathyroid disease or high blood calcium
☐	☐	☐	pituitary disease
☐	☐	☐	adrenal disease
☐	☐	☐	gonadal disease
			Family History
☐	☐	☐	diabetes, high blood sugar
☐	☐	☐	hypertension, high blood pressure
☐	☐	☐	hyperlipidemia, high cholesterol or triglyceride
☐	☐	☐	cardiovascular (heart or blood vessel) disease
☐	☐	☐	thyroid disease
☐	☐	☐	other hormonal diseases
			Social History
☐	☐	☐	Do you smoke? How long?_____ yrs. How much?_____ packs.
☐	☐	☐	Do you drink alcohol? How much? _____.
☐	☐	☐	Do you use recreational drugs? Which? _____.
☐	☐	☐	Do you engage in hazardous activities? What? _____.

Addressed by Provider	Yes	No	
			Diabetes Self-Management Questionnaire
☐	☐	☐	Have you been to the hospital emergency room in the past year specifically because of diabetes?
☐	☐	☐	Have you had a dilated eye examination within the last year?
☐	☐	☐	Do you inspect your feet daily?
☐	☐	☐	Do you follow diabetes foot care guidelines?
☐	☐	☐	Have you seen a registered dietitian in the last year?
☐	☐	☐	Do you follow a diabetes meal plan?
☐	☐	☐	Are you involved in a regularly scheduled exercise program?
☐	☐	☐	Do you monitor your blood glucose daily?
☐	☐	☐	Do you record all blood glucose results in a logbook?
☐	☐	☐	Do you follow guidelines for treating hypoglycemia?
☐	☐	☐	Do you follow diabetes sick-day guidelines?
☐	☐	☐	Have you received an influenza vaccination in the last year?
☐	☐	☐	Have you received a pneumonia vaccination in the last 5 years?

Please make additional comments here:

Patient signature:

Practitioner signature:

Date:

Date: