COMPLETE ENDOCRINOLOGY
2200 S. 40th St., Suite 102
Lincoln, NE 68506
Phone: 402-405-0500
Fax: 402-405-0505

Please list primary care providers and specialists involved in your care whom you would like to receive copies of your clinical notes and labs done at Complete Endocrinology:

_____

_____

***Please circle Y or N to the following questions. If you answer yes, please give additional information.***

- When were you diagnosed with diabetes? _____
- Do you have diabetic retinopathy? (damage to your eyes due to diabetes) Y or N
  - Any past retinal laser treatment or surgery? Y or N _____
- Do you have diabetic neuropathy (damage to your nerves due to diabetes)? Y or N
  - Any prior foot ulcers? Y or N _____
  - Any past amputations? Y or N _____
- Do you have diabetic nephropathy (kidney damage due to diabetes)? Y or N
- Do you have kidney disease (caused by a condition other than diabetes)? Y or N
  - Are you on dialysis? Y or N
  - Have you had a kidney transplant? Y or N _____
- Have you ever had diabetic ketoacidosis? Y or N _____
- Do you have high blood pressure? Y or N
- Do you have high cholesterol? Y or N
- Do you have heart disease? Y or N
  - Have you had a CABG? (coronary artery bypass graft) Y or N _____
  - Have you ever had a heart stent placed? Y or N _____
- Are you a smoker? Y or N
- Do you have vascular disease? (blockage of blood flow in vessels in arms or legs) Y or N
- Have you had a stroke or TIA (Transient Ischemic Attack)? Y or N
- Do you have any erectile dysfunction? Y or N
- Do you suffer from depression? Y or N
- Have you had diabetes education in the past? Y or N _____
  - When was your last pneumonia vaccine? _____
  - When was your last flu vaccine? _____
  - When was your last dental exam? _____
- Do you check urine ketones when ill or when blood sugars are running high? Y or N
- Do you exercise? Y or N Explain: _____
- Describe your diet: _____
- How many times a day do you check your blood sugars? _____
- What brand of glucose meter do you use?: _____
- Do you recognize symptoms of low blood sugars? Y or N
  - How often do you have low blood sugars? _____
  - What causes you to have low blood sugars? _____
  - Do you have a glucagon emergency kit? Y or N
  - Do you wear a medic alert ID? Y or N




Place Patient Label Here

**Care Team**
Please list your primary care provider and specialists you see. We will send notes and labs from our office to these providers.

_____

When were you fist diagnosed with diabetes?

_____

What type of diabetes do you have? (circle one) Type 1 / Type 2 / Unsure

Have you been diagnosed with Pancreatitis? Y or N

Have you had diabetic education? Y or N Year of last visit: _____

Describe your diet (eating habits, carb/calorie intake, caffeine intake, etc.)

_____

Do you exercise? Y or N
Explain: _____

How old is your glucose meter?

_____

Do you see a foot doctor or wear diabetic shoes? Y or N

Date of last Eye Exam: _____ Eye Doctor/Clinic: _____

Date of last Dental Exam: _____

Vaccines recommended for diabetes (please list date):

- Last influenza Vaccination: _____
- Pneumonia Vaccine (Pneumovax 23, Prevnar): _____
- Hepatitis B Vaccine: _____

**Social History**

- Do you live alone or with others? _____
- Are you currently employed? Y or N
  - Employer: _____
- What is your occupation? _____
- Do you smoke tobacco? Y or N If yes, how long have you smoked and how often?

  _____
- Do you drink alcohol? Y or N If yes, how much and how often?

  _____
- Do you use drugs? Y or N If yes, how much and how often?

  _____

## Past Medical History

Please list your medical conditions (ex: high blood pressure, diabetes, heart disease, depression, hypothyroidism, etc.)

## Past Surgical History

Please list your prior surgeries with age and/or year of surgery if known



Place Patient Label Here

## Family History:

| | Medical Problems | Age of Death |
|---|---|---|
| Father | | |
| Mother | | |
| Sibling(s) | | |
| Children | | |
| Other | | |

## Medications:

| Medication | Dosage | Time of Day Taken | Reason You Take |
|---|---|---|---|
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## Allergies:

| Medication/Food/Exposure | Reaction | Date |
|---|---|---|
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| | | |

**Review of Systems**

Please circle if you have any of the following symptoms, and if present please provide additional information:

- Excess weight gain, excess weight loss, loss of appetite, fever, diminished activity, fatigue

- Eye pain, blurry vision, eye redness, eye itchiness, eye swelling, eye discharge, eyes bulging out, seeing double vision, vision loss

- Ear pain, hearing loss, sinus pressure, swelling, congestion, sore throat, hoarseness, mouth lesions, foul smelling breath, sneezing, runny nose

- Chest pain, chest pressure, rapid heart rate, palpitations, slow heart rate

- Cough, wheezing, chest tightness, pain with respiration, noisy breathing, rapid breathing, difficulty breathing, shortness of breath with activity

- Difficulty swallowing, abdominal pain, nausea, vomiting, diarrhea, constipation, blood in stools

- Blood in the urine, pain during urination, increased frequency of urination, voiding urgency, vaginal discharge, heavy menses, irregular menses, no menses, pelvic pain

- Leg swelling, joint swelling, limited motion, previous injuries, muscles aches

- Itchy skin, dry skin, flaking, redness, rash, hives, skin lesions, swelling, darkening of skin around neck or underarms

- Numbness, weakness, tingling, burning, shooting pain, headache, dizziness, loss of consciousness

- Increased thirst, heat or cold intolerance



Place Patient Label Here