

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

**Bryan Physician Network**

**DIABETES HISTORY**



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 first 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.)

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**Past Surgical History**

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

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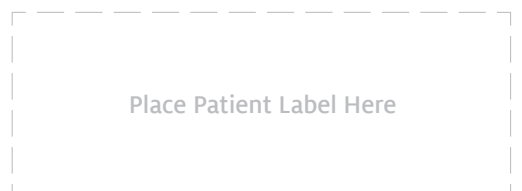
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**Family History:**

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

**Medications:**

Medication	Dosage	Time of Day Taken	Reason You Take

**Allergies:**

Medication/Food/Exposure	Reaction	Date

**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

\_\_\_\_\_

