Premier Health
Premier Physician Network

Bull Family Diabetes Center
400 Sugar Camp Circle, Suite 205
Dayton, OH 45409

NEW PATIENT QUESTIONNAIRE

Please help us by filling out this form before your visit with the doctor. If you need help, please call (937) 395-3656 or notify the front desk or medical assistant when you come to your appointment.

NAME _____ Date of Birth_____ Today's Date: _____

When were you diagnosed with diabetes? (year of diagnosis and age)	
What was your approximate weight at that time?	
Have you been hospitalized for diabetes? If so, list dates and reason.	
Do you have any complications related to diabetes? (eye, kidney, nerve, heart, *please indicate which*)	
Have you needed someone else's help, called emergency services or had a car accident due low blood sugars? Please indicate approximate dates.	
What is date of your last diabetic eye exam?	
What is the date of your last diabetic foot exam?	
Have you had diabetes education classes? If so, when and where? Describe education received.	
Which glucose meter do you use?	
How many times a day do you test your blood sugar?	
What are your lowest and highest blood sugars?	

CIRCLE ALL treatments you have tried for Diabetes:

Drug Name (CIRCLE)	Current use	Past use (dates used)	Reason for Stopping
Metformin, metformin XR, Glumetza, Glucophage XR			
pioglitazone, rosiglitazone			
acarbose			
glimepiride, glipizide, glyburide, nateglinide, repaglinide			
Welchol			
Cycloset			
Byetta, Bydureon, Victoza, Tanzeum, Trulicity, Ozempic			
Symlin			
Januvia, Janumet, Onglyza, Kombiglyze, Tradjenta, Jentadueto, Nesina, Kazano, Oseni			
Invokana, Invokamet, Farxiga, Xiguduo, Qtern, Jardiance, Synjardy, Glyxmabi, Steglatro, Stegujan, Stegluromet			
HIGHLY CONCENTRATED U-500 regular insulin			
INSULIN: **Long acting insulin**: NPH, Lantus, Toujeo, Basalgar, Levemir, Tresiba **Short or rapid acting insulin**: Humalog, NovoLog, Apidra, Admelog, Fiasp, Regular, Afrezza (inhaled) **Mixed insulin:** Humulin/Novolin 70/30, Humalog Mix 75/25, Humalog Mix 50/50, NovoLog Mix 70/30			
Soliqua, Xultophy			

Current Medications **PLEASE BRING A LIST OF YOUR MEDICATIONS TO *ALL* APPOINTMENTS.** REMEMBER TO INCLUDE INJECTED, INHALED MEDICATIONS, DIABETIC SUPPLIES, VITAMINS, SUPPLEMENTS AND MEDICATIONS PURCHASED OVER-THE-COUNTER.

TURN PAGE OVER ⇨

General Medical History (check all that apply)

- ❑ Anemia
- ❑ Asthma
- ❑ Arthritis
- ❑ Cancer or tumors
- ❑ Cataract(s)
- ❑ CHF/ Heart failure
- ❑ Blood clots
- ❑ Diabetes
- ❑ Depression
- ❑ Emphysema or COPD
- ❑GERD/ Reflux
- ❑Glaucoma
- ❑ HIV/AIDS
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Heart attack
- ❑ Heart disease
- ❑High cholesterol
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Seizures
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Hypothyroidism
- ❑ Hyperthyroidism
- ❑ Stomach ulcers
- ❑Frequent UTIs
- ❑ Fibromyalgia
- ❑ Intestinal bleeding
- ❑ Liver disease
- ❑ Gall Bladder disease
- ❑ Kidney stones
- ❑ Gastroparesis
- ❑ Pancreatitis
- ❑ Gout

Please write other health problems not listed above.

_____

_____

Hospitalizations and Operations

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medication Allergies List any medication allergies and the type of reaction that occurs.

_____

_____

Immunizations List date completed.

Tetanus booster		Pneumovax (pneumonia)		Influenza (flu)	
Hepatitis B		Shingles			

Family History (check, indicate who)

Diabetes ❑No ❑Yes, who:_____

High blood pressure ❑No ❑Yes, who:_____

High cholesterol ❑No ❑Yes, who:_____

Heart Disease ❑No ❑Yes, who:_____

Other Cancer ❑No ❑Yes, who, what type? _____

Osteoporosis ❑No ❑Yes, who:_____

Thyroid problems ❑No ❑Yes, who:_____

Thyroid cancer ❑No ❑Yes, who:_____

Other_____

_____

Social History

Occupation	**Highest level of education**	**❑single ❑married ❑divorced ❑widowed**

Substances used	**Yes or No**	**How Much and What**
Alcohol		
Tobacco		
Addictive drugs		

Do you exercise?	**How Often/What Activities?**	**What Limits Your Physical Activity?**

TURN PAGE OVER ⇨

Review of Systems (check symptoms you have had recently)

General
- ❑ Activity change
- ❑ Appetite change
- ❑ Sweating
- ❑ Fatigue
- ❑ Unexpected weight change

Head/Ear/Nose/Throat
- ❑ Sinus congestion
- ❑ Dental problems
- ❑ Hearing loss
- ❑ Trouble swallowing
- ❑ Voice change

Eyes
- ❑ Light sensitivity
- ❑ Vision changes

Breathing and Lungs
- ❑ Snoring /Apnea
- ❑ Cough
- ❑ Shortness of breath
- ❑ Wheezing

Heart
- ❑ Chest pain/tightness
- ❑ Leg swelling
- ❑ Palpitations

Stomach/Intestinal
- ❑ Abdominal bloating
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting

Gland/Hormone
- ❑ Increased thirst
- ❑ Increased urination

Genitourinary
- ❑ Difficulty urinating
- ❑ Painful urination
- ❑ Incontinence
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Urgency
- ❑ Decreased urination

Muscle and Skeletal
- ❑ Joint pains
- ❑ Back pain
- ❑ Walking difficulties
- ❑ Joint swelling
- ❑ Muscle aches

Skin
- ❑ Rash
- ❑ Wound/sores/ulcers

Neurological
- ❑ Dizziness or lightheaded
- ❑ Headaches
- ❑ Numbness or tingling pain
- ❑ Passing out/losing consciousness
- ❑ Weakness

Hematologic
- ❑ Lymph gland swelling
- ❑ Easy bruising

Psychiatric
- ❑ Confusion
- ❑ Depression
- ❑ Nervousness/anxiety
- ❑ Sleep disturbance

What type of diet to you follow? _____

Time of Breakfast? _____ Lunch _____ Supper _____ Snacks _____

Do you skip meals? _____

Beverage preferences: _____

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