Additional Intake Form for New Diabetic Patients:

Patient Name
_____DOB_____

Have you currently been diagnoses with one of the following (please circle):

Pre-Diabetes Type 1 Diabetes Mellitus Type 2 Diabetes Mellitus

Gestational Diabetes Other form of Diabetes_____

When were you diagnosed with Diabetes?: _____

What medications do you take to control your Diabetes?:
_____

_____
_____

How often do you check your blood sugar?:

□Daily □Several times a week □Several times a month

□I don't check my blood sugar

What does it usually read?: _____

What was your last A1C?: _____What was the highest your A1C ever was?
_____

Have you ever had a wound that is slow to heal (8-12 weeks)?: □ Yes □ No

If yes, where the location of the wound(s)?: _____
_____
___

Do you ever get any of the following? □burning □tingling □numbness □shooting pain

If so, how often do you get these sensations?: □Daily □Several times a week □Several times a month □Several times a year

Have you ever been diagnosed with Neuropathy? □Yes □No

If Yes, do you take medications for it? □No

□Gabapentin/Neurontin □Lyrica/Pregabalin □Metanx □Duloxetine/Cymbalta

□Amitriptyline/Elavil/Amitid/Endep/Amitril

□Other Meds (including topical creams)_____