USF DIABETES CENTER
UNIVERSITY OF SOUTH FLORIDA

USF HEALTH

ADULT NEW PATIENT FORM

Today's Date:	Name of Person Completing this form:	Relationship to Patient:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Nickname:	Date of Birth:	Age:

Sex: ☐ M ☐ F

Social Security Number

Language spoken at home:

Race/Ethnicity:

☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino/Mexican

☐ Asian/Chinese/Japanese/Korean ☐ Native Hawaiian/Pacific Islander ☐ American Indian

☐ Other

Street address:

Home Phone #: ( )

Cell Phone # ( )

Email :

P.O. Box:	City:	State:	ZIP Code:

Referred to the Center by (Please check one box):

☐ Physician ☐ Hospital ☐ Insurance plan ☐ Friend ☐ Family ☐ Self ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Alt phone #:
		(_____)_____	(_____)_____

CONSULTATION INFORMATION

Name of Referring Physician:	Phone #:

Address including City, State and Zip :

Name of Primary Physician (if different from above):	Phone #:

Address including City, State and Zip :

Why did you come to the Diabetes Center today?

☐ Newly Diagnosed ☐ Poorly Controlled Diabetes ☐ Testing For Possible Diabetes ☐ Research Study Participation

☐ Insulin Pump Therapy ☐ Continuous Glucose Monitoring ☐ Diabetes Education ☐ Counseling Services

Please list any problems/concerns that you feel need to be discussed at this appointment:

FAMILY & SOCIAL HISTORY

	Lives at home	Age	Student/ Occupation
Mother	☐ Yes ☐ No		
Father	☐ Yes ☐ No		
Significant other	☐ Yes ☐ No		
Child	☐ Yes ☐ No		
Child	☐ Yes ☐ No		
Child	☐ Yes ☐ No		
Other	☐ Yes ☐ No		

Do you:

Smoke? ☐ Yes ☐ No # of packs: _____ Does anyone else in family? ☐ Yes ☐ No

Chew tobacco? ☐ Yes ☐ No How often: _____ Does anyone else in family? ☐ Yes ☐ No

Use alcohol? ☐ Yes ☐ No # of drinks per week: _____ Does anyone else in family? ☐ Yes ☐ No

Use drugs? ☐ Yes ☐ No What type and how often: _____ Does anyone else in family? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No If yes, is contraception used? ☐ Yes ☐ No

What special religious observances would you like us to know about? _____

PSYCHOSOCIAL HISTORY

I have concerns about (check all that apply):

☐ Fear of needles ☐ Family conflicts about diabetes ☐ Telling others about diabetes
☐ Going to work with diabetes ☐ Stress ☐ Overall care of myself
☐ Going to college with diabetes ☐ Other:

1. Do you have one or more symptoms of depression (for example: sadness, anger, irritability, not having fun in activities, sleep problems)?
   ☐ Yes ☐ No
2. Do you have one or more symptoms of anxiety or nervousness? (for example: difficulty staying away from home, avoiding thing or situations that makes he/she frightened) ☐ Yes ☐ No
3. Are you having difficulty coping with your diabetes? ☐ Yes ☐ No
4. Please check any of the following stressful events that have happened to you over the past year:

   ☐ Frequent problems getting along with family ☐ Frequent problems getting along with friends ☐ Move to new school or home

   ☐ Divorce or separation of parents ☐ Negative change in family's financial circumstances ☐ Remarriage of parents

   ☐ Death of a family member or close friend ☐ Other major life change or stressful event
5. Would you like to speak to the Diabetes Center psychologist about mood, behavior or coping? ☐ Yes ☐ No

PATIENT MEDICAL HISTORY

Medical Condition Please check yes if you have been diagnosed with any of the following medical conditions		Comments:
High or low blood pressure	☐ Yes	
Autoimmune disorders (e.g. Celiac, Lupus, Crohns Disease, Ulcerative Colitis, Rheumatoid Arthritis, Vitiligo)	☐ Yes	
Heart murmur	☐ Yes	
High cholesterol/Abnormal Lipids	☐ Yes	
Thyroid disease	☐ Yes	
Liver problems	☐ Yes	
Kidney problems	☐ Yes	
Cancer	☐ Yes	
History of Chemotherapy/radiation	☐ Yes	
Anemia (low blood count)	☐ Yes	
History of blood transfusion	☐ Yes	
Meningitis	☐ Yes	
Seizures	☐ Yes	
Head injury	☐ Yes	
Abnormal growth/weight problems as a child/young adult	☐ Yes	
Calcium problems	☐ Yes	
Kidney stones	☐ Yes	
Bone problems	☐ Yes	
Early/late puberty	☐ Yes	
Adrenal gland problems (Addison disease)	☐ Yes	
Abnormal sex organs	☐ Yes	
Pituitary gland problems	☐ Yes	
Hearing Problems	☐ Yes	
Learning disabilities	☐ Yes	
Autism/Asperger's Syndrome	☐ Yes	
Mental Retardation	☐ Yes	
Ear Infections	☐ Yes	
Other	☐ Yes	

Please describe all previous hospitalizations, dates, age, and reason

Hospitalization Date	Age	Reason

Please list all previous surgeries and approximate date and age at surgery

Surgery Date	Age	Reason

Please list any **allergies** that you have: _____

_____

Are your immunizations up to date? ☐ Yes ☐ No

Have you received a flu shot? ☐ Yes ☐ No If yes, when was last one given? _____

Have you had the pneumovax (pneumonia vaccine?) ☐ Yes ☐ No If yes, when was last one given? _____

Review of systems:	Yes	Please describe
Feeling fine	☐	
Normal appetite	☐	
Recent weight change	☐	Weight Loss # lbs _____ Weight Gain # lbs _____
Normal Level of activity	☐	
Headache	☐	
Fever	☐	
Frequent infections	☐	
Birth Defects	☐	
SKIN		
Birthmarks/Rashes/Skin coloring/Acne	☐	
Stretch marks	☐	
Dark appearing skin on neck or in skin folds	☐	
EYES	☐	
Vision Problems	☐	
Needs eyeglasses or wears contacts	☐	
EAR, NOSE, THROAT		
Normal Sense of smell	☐	
Lumps or pains in the neck	☐	
Difficulty swallowing/Change in voice	☐	
CARDIOVASCULAR		
Palpitations/Fast heart beat	☐	
RESPIRATORY		
History of asthma or other lung disease	☐	
Use of steroids to aid breathing	☐	
Difficulties in breathing/wheezing	☐	
Cough	☐	
GASTROINTESTINAL		
Constipation (hard bowel movements)	☐	
Diarrhea (liquid stools)	☐	
Vomiting	☐	
Stomach pains	☐	
GENITOURINARY		
Kidney/bladder problems	☐	
ENDOCRINE		
Gets very cold or very hot easily	☐	
Early or late sexual development	☐	
Breast discharge	☐	
Adult body odor	☐	
Abnormal facial/body hair	☐	
Vaginal discharge	☐	
Menstrual periods (regularity, length, etc.)	☐	Date of 1st menstrual period_____
Hypoglycemia (low blood sugar)	☐	
Fainting	☐	
Convulsions	☐	
Excessive thirst	☐	
Excessive hunger	☐	
Excessive urination/	☐	
Bedwetting/Urinary accidents	☐	
HEMATOLOGIC/ONCOLOGIC		
Easy bruising or bleeding	☐	
MUSCULOSKELETAL		
Muscle pains or weakness	☐	
Joint pain or swelling	☐	
Swelling of hands or feet	☐	
NEUROLOGIC		
Abnormal head size	☐	
PSYCHIATRIC/DEVELOPMENTAL		
Hyperactivity/Behavior Problems	☐	
Depression	☐	
Nervousness	☐	

Family Medical Condition	**YES**	Relationship Of Family Member To Patient
Diabetes	☐	
High or low blood pressure	☐	
Autoimmune Disorders (e.g. Celiac, Lupus, Crohns Disease, Ulcerative Colitis, Rheumatoid Arthritis, Vitiligo, Multiple sclerosis)	☐	
Heart murmur	☐	
High cholesterol/Abnormal lipids	☐	
Heart disease/Stroke	☐	
Death from heart disease	☐	How old was your relative when they died?
Thyroid disease	☐	
Liver problems	☐	
Kidney problems	☐	
Cancer	☐	
History of Chemotherapy/radiation	☐	
Anemia (low blood count)	☐	
History of blood transfusion	☐	
Meningitis	☐	
Seizures	☐	
Head injury	☐	
Abnormal growth/weight problems	☐	
Calcium problems	☐	
Kidney stones	☐	
Bone problems	☐	
Early/late puberty	☐	
Adrenal gland problems (Addison disease)	☐	
Abnormal sex organs	☐	
Pituitary gland problems	☐	
Hearing Problems	☐	
Learning disabilities	☐	
Autism/ (Asperger's Syndrome)	☐	
Mental Retardation	☐	
Ear Infections	☐	
Other	☐	

DIABETES HISTORY		
Date and location of diagnosis:	Were you admitted to the hospital? ☐ Yes ☐ No	Length of stay: _____
Were you diagnosed with diabetic ketoacidosis? ☐ Yes ☐ No ICU stay? ☐ Yes ☐ No If yes, the # of days in ICU: _____		
Have you had previous diabetes education? ☐ Yes ☐ No If yes, where and when?		
How often do you see your primary care doctor?		
What was the last date and result of your Hemoglobin A1C test?		
What kind of blood glucose meter do you use to test blood sugars?		
How often do you test your blood sugar?		
What target range do you try to keep the blood sugars between?		
How often do you have a low blood sugar?		
What do you consider a low blood sugar?		
When is a low blood sugar most likely to occur?		
What symptoms occur if the blood sugar is low?		
How do you treat a low blood sugar?		
Do you have Glucagon? ☐ Yes ☐ No If yes, what is the expiration date? _____		
When do you use Glucagon?		
Have you ever had any seizures or unconscious episodes? ☐ Yes ☐ No If yes, include dates and times:		
How often is the blood sugar over 250mg/dl?		
When is a high blood sugar most likely to occur?		
Do you have Ketostix? ☐ Yes ☐ No		
Do you test urine/blood for ketones? ☐ Yes ☐ No If yes, what do you do if ketones are present?		
Have there been hospitalizations for high blood sugars or diabetic ketoacidosis since diagnosis? ☐ Yes ☐ No If yes, include dates and times of the hospitalizations:		

DIABETES MEDICATIONS

Oral Medication / Other Injectables (Byetta, Victoza, Symlin)
Please list other oral medication and injectables other then insulin taken below:

Medication	Dosage	Times Taken

Insulin Injections

What basal insulin do you take? ☐ **Lantus** ☐ **Levemir** ☐ **NPH** ☐ **Other**_____

Time _____ **AM** _____ **units** _____**PM** _____ **units**

What bolus (meal/snack) insulin do you take?

☐ **Humalog** ☐ **Novolog** ☐ **Apidra** ☐ **Regular** ☐ **Other**_____

Dosing Regimen:

	Insulin	Dosage Range List the range of units given before meals List your carbohydrate insulin ratio if you are carbohydrate counting
Breakfast		
Lunch		
Dinner		
Bedtime		
Other		

Correction Scale: (Please describe how you cover a high blood glucose?)

Insulin Injection Management

What do you use to inject insulin? ☐ Syringes ☐ Pen (include what kind)

Do you injection your insulin? ☐ Yes ☐ No
If no, who injects for you? ☐ Spouse ☐ Mother ☐ Father ☐ Sibling ☐ Son/Daughter

What injection sites do you use? ☐ Arm ☐ Thigh ☐ Hip ☐ Abdomen ☐ Buttocks ☐ Other

Do you rotate your sites? ☐ Yes ☐ No If not, why?

Have you had any problems since your last clinic visit when giving injections? (please check all that apply)

☐ bleeding ☐ leakage ☐ bruising ☐ other_____

How often do you forget/miss giving an insulin injection each day? (please check)

☐ 1x/day ☐ 2x/day ☐ 3x /day ☐ 1-2X every other day ☐ 1-2x weekly ☐ rarely

Which insulin dose are you more likely to miss and why? (Please describe situation causing you to miss your dose)

Insulin Pump Therapy please fill out this section if you are using an insulin pump

When was pump therapy started?	Who prescribed it?
What is the brand and model of the pump?	What type of infusion set is used?
Is it the short cannula? ☐ Yes ☐ No	Do you ever get infections at the site? ☐ Yes ☐ No If yes, how often?
How often do you change the infusion set?	Any problem with the infusion set not sticking to the skin? ☐ Yes ☐ No

What insertion sites are used? ☐ Arm ☐ Thigh ☐ Hip ☐ Abdomen ☐ Buttocks ☐ other

Do you adjust basal rates? ☐ Yes ☐ No	Do you ever use temporary basal rates? ☐ Yes ☐ No
Do you use alternate basal patterns? ☐ Yes ☐ No If so, for what event?	
Do you adjust your bolus settings? ☐ Yes ☐ No	Do you use extended (square or dual wave) food boluses? ☐ Yes ☐ No
Do you have syringes? ☐ Yes ☐ No	Where do you get your pump supplies?

Any problems receiving pump supplies? ☐ Yes ☐ No

Do you have a plan for injections in the event of pump failure? ☐ Yes ☐ No

Do you use injections in addition to what your pump delivers? ☐ Yes ☐ No ☐ Sometimes

Do you have a prescription for long acting insulin? ☐ Yes ☐ No If yes, what type of insulin?

Do you disconnect from the pump more than one hour a day? ☐ Yes ☐ No

If yes, why, how long, how often?

What plan do you use when disconnected to the pump?

At what blood sugar level do you treat low blood glucose?

How do you treat low blood glucose? ☐ Suspend ☐ Quick Carb ☐ Temporary Basal Rate Decrease

NUTRITION

Have you been given a diabetes meal plan? ☐ Yes ☐ No | When? By Whom?

If yes, what kind?
- ☐ Exchange lists for meal planning
- ☐ Consistent Carb ranges for meals and snacks
- ☐ Carbohydrate Counting Carb Insulin Ratio is:
- ☐ Other (please explain)

If you do not have a meal plan, how do you decide what foods to eat? Check all that apply.

- ☐ Eat whatever I want
- ☐ Eat until I'm full
- ☐ Avoid/limit sugar and sweets
- ☐ Limit intake of starchy foods
- ☐ Limit intake of fatty or fried foods
- ☐ Eat whatever is available
- ☐ Eat Out Frequently

Please describe any changes you would like made in your meal plan:

What do you drink? (*Check all that apply*)

- Water ☐ how many glasses/day _____
- Soda ☐ how many glasses/day _____
- Diet drinks ☐ how many glasses/day _____
- Sports drinks ☐ how many glasses/day _____
- Juice ☐ how many glasses/day _____

☐ skim ☐ 1% ☐ 2% ☐ Whole Milk How many glasses/day _____

Do you take vitamin Supplements? ☐ Yes ☐ No

If yes, please list:

What factors make it a challenge to follow a meal plan? (check all that apply)

- ☐ Changes in appetite
- ☐ Frequent low blood sugars
- ☐ Peer or social pressures
- ☐ School or work schedule
- ☐ Activity schedule
- ☐ Food not available
- ☐ Too much food in meal plan
- ☐ Not enough food in meal plan
- ☐ Not hungry
- ☐ Disliking food
- ☐ Cost of food
- ☐ Bingeing
- ☐ Purging
- ☐ Other

Who usually prepares your meals?

- ☐ I prepare my own meals
- ☐ Spouse
- ☐ Parent or Grandparent
- ☐ Family/friend who lives with you
- ☐ Other person(s)
- ☐ Eat out most of time

Self- Image

Are you happy with your current weight? ☐ Yes ☐ No

Would you like to weigh less or more?	Describe:

Mail or fax this form to: USF Diabetes Center, 12901 Bruce B. Downs. Blvd, MDC 62, Tampa, FL 33612
Secure Fax: (813)974-3313 Phone: (813)396-2580

Physician/Provider Signature:_____

Date:_____