**HELP YOUR DIABETES**

**NEW PATIENT APPLICATION**

*(PLEASE PRINT)*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s date: |  |  |  |  |  |  |  |  |  | Wellness Coordinator: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | **PATIENT INFORMATION** |  |  |  |  |  |  |  |  |  |  |  |
| Last Name: |  |  |  |  |  | First: |  |  |  | q Mr. |  | q Miss |  | Marital status (circle one) |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | q Mrs. |  | q \_\_\_\_\_ |  | Single / Mar / Div / Sep / Wid |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Height: | Weight: |  | Home Phone #: |  | Mobile Phone #: |  |  |  | Birth date: |  | Age: |  | Sex: |  |  |
|  |  |  |  | ( | ) |  |  | ( | ) |  |  |  | / |  |  | / |  |  | q M | q F |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Street address: |  |  |  |  |  |  |  |  |  |  |  |  |  | Spouse’s Name: |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| City: |  |  |  |  | State: | Zip Code: | Email: |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Occupation: |  |  |  |  | Employer: |  |  |  |  |  |  |  |  | Length of Employment |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Referred to *HYD* by (please check one box): | q Newspaper |  |  | q Radio | q Postcard | q TV |  |  | q Free Booklet |  |  |  |
| q Facebook | q Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | q Internet Search |  |  |  | q Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| q Signage on Building | q Received Phone Call |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



Do you know someone who’s been through the



HYD Program?



**DIABETES HISTORY**

(Please give your lab work to your Wellness Coordinator, if you have it with you)

When were you diagnosed with Type 2 Diabetes? Month / Year

q Blurred Vision (retinopathy)

q Neuropathy (tingling, numbness, burning pain, Restless Leg Syndrome)

q Increased Urination

Diabetic Symptoms (list all) q Low Sex Drive

q High Blood Pressure

q Lack of Energy

q Difficulty Sleeping

|  |  |
| --- | --- |
| How often do you have symptoms? | When did your symptoms start? |
|  |  |
| Do you feel like your current treatments are helping your Diabetes? q Yes | q No |
|  |  |
| Why do you want to Reverse Your Diabetes? |  |

On a Scale of 1 to 10 (10 being the highest motivation) how motivated are you to reverse your diabetes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you understand that you will have to make some lifestyle changes to reverse your diabetes? q Yes q No

Are you willing to make some lifestyle changes? q Yes q No

**BLOOD SUGAR**

|  |  |  |
| --- | --- | --- |
| Blood Sugar **WITHOUT** Medications |  | Blood Sugar **WITH** Medication |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HIGHEST |  |  |  |  |  |  | HIGHEST |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| LOWEST |  |  |  |  |  |  | LOWEST |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **Last A1C:** |  |  |  |  | **Last Fasting Blood Sugar:** |  |  | **Last Blood Pressure**: |
| Date Taken: |  |  |  |  | Date Taken: |  |  | Date Taken: |
|  |  |  |  |  |
| **Do You Check Your Blood Sugar?** |  |  |  |  | q **Explained To Patient To Purchase** |
|  |  |  |  |  | q **Explained To Patient To Check BS Daily** |  | **Glucose Monitor Because They** |
| **\_\_\_\_\_ Day \_\_\_\_\_Week** | q **Never Check** |  |  |  |  | **Don’t Have One** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |



**MEDICATIONS**



**MEDICAL AND SOCIAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surgeries / Hospitalizations** | **Date** | **Trauma** | **Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Past / Recent Illness** | **Date** | **Allergies** | **Date** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |



Which of these common diabetic complications concerns you the most?

q Blurred Vision that can lead to blindness

q Kidney stress that can lead to dialysis

q High Blood Pressure that can lead to heart attack or stroke q Neuropathy that can lead to amputations

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | # of Children? |  |  |  |  |  |  | # of Grand Children? |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Alcohol | Y | / | N |  |  |  |  | Drinks per week |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Tobacco | Y | / | N |  |  |  |  | Packs per day |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | Caffeine | Y | / | N |  |  |  |  | Cups per day |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Patient Signature** |  |  |  | **Date of Consultation** |  | ***HYD* Doctor Approval for Program** |  | **Date** |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

