Southern Diabetes Care
Family Endocrinology Center

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If any information does not apply to you—skip over and move to next section.

Patient Information	
First Name: Middle Name: Last Name:	Date of Birth: Sex:
Social Security Number:	Race: asdf Ethnicity:
Address:	City, State, Zip:
Primary Language:	Employer/Occupation:
Home Phone: Cell Phone: Work Phone:	Primary Care Provider: Pharmacy: Pharmacy Contact #:
Blood Glucose Monitoring	
Do you check glucoses at home: Yes __ No __ How often: _____	What type of meter is used?
Continuous Glucose Monitoring	
Do you use CGM? Yes ___ No ___	What CGM is used? Supplies from?
Insulin Pump	
Do you use insulin pump? Yes ___ No ___	What pump is used? Year started *this* pump? Supplies from?

Diabetes History		
Year diagnosed:	Family History: Yes ___ No ___	Family Members with Diabetes: _____ _____ _____
Last ER/Hospital Visit for Diabetes: _____	Any prior diabetes education: Yes ___ No ___ Year _____	History of Diabetes with Pregnancy: Yes ___ No ____ Year ____

Medication Allergies

Diet	
Any cultural practices: Yes ___ No ___ Explain: _____ _____	# of meals per day: ___ Snack often? Yes ___ No ___

Physical Activity:	
Any exercise? Yes ___ No ___	How often? _____ What type: _____

Medical History:	Surgical History:	Family History:

Social History:

Tobacco:	Alcohol:	Caffeine:	Vaping:
o Ever used: Yes __ No __ o Age Started: _____ o Current use: Yes __ No ___ o Amount per day: ½ pack ___ 1 pack ___ Socially ___ _____ (other) o Type of tobacco: Cigarettes ___ Cigar/Cigarello ___ Chewing/Snuff ___ Pipe ___ o Passive Exposure: Yes ___ No ___ In the Home? Yes ___ No ___ Tobacco Type: _____ o Ever tried to quit? Yes ___ No ___ Year Quit: _____	o Do you drink alcohol? Yes ___ No ___ o Frequency? Daily ___ Weekly ___ Monthly ___ Socially ___ o Amount? 1 drink ___ 1-2 drinks ___ >3 drinks ___ _____ (other)	o Do you drink caffeine? Yes ___ No ___ o Type: Coffee ___ Chocolate ___ Energy Drinks ___ Tea ___ Soda ___ o Amount: _____ cups	o History of Vaping Use? Yes ___ No ___ o Current Use of Vape? Yes ___ No ___ o Age started: _____ o Frequency: Daily ____ Weekly ____ Socially ____ o Device Type: _____ o Ever tried to quit? Yes ___ No ___ o Year Quit: _____

Medication Record:

Medication Name	Dose	Frequency	Time Taken