



345 Clyde Morris Blvd Suite 390  
Ormond Beach Fl, 32174  
386-673-0075

## GUPTA MEDICAL SPECIALISTS

NEW PATIENT INFORMATION FORM -*DIABETES*

Please print all information. Thank you for your cooperation.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Work/Cell: \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status:    Single        Married        Divorced        Widowed

Email Address: \_\_\_\_\_

Is it ok to mail correspondence such as reminders and letters to you?    \_\_\_ Yes \_\_\_ No

Referring Physician or Referral Source:

\_\_\_\_\_

Primary Care Physician:

\_\_\_\_\_

Do you want your medical records sent to this practice?    \_\_\_ Yes \_\_\_ No

Insurance Plan: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Issue Date: \_\_\_\_\_

Secondary Insurance Plan: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Issue Date: \_\_\_\_\_

**Thank you for taking the time to complete our intake forms.** Please sign & date (below)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

**HISTORY OF PRESENT ILLNESS**

1. Age:\_\_\_\_\_ Male Female          Diabetes: Type I    Type II
2. When were you diagnosed with diabetes? \_\_\_\_\_
3. How were you diagnosed? \_\_\_\_\_
4. Have you ever been hospitalized for diabetes? No    Yes    If yes, where and when (diabetic ketoacidosis, hyperosmolar state)  
\_\_\_\_\_  
\_\_\_\_\_
5. What type of glucometer do you use? \_\_\_\_\_
6. How many times a day do you check your sugar? \_\_\_\_\_
7. How many meals a day do you eat? \_\_\_\_\_ How many snacks? \_\_\_\_\_
8. What are your average sugars at:  
Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_ Bedtime: \_\_\_\_\_
9. Have you ever had a hypoglycemic (low sugar level) episode requiring assistance from another person to recover? \_\_\_\_\_
10. How many times do you urinate at night? \_\_\_\_\_
11. Do you exercise and if so for how many minutes and how many days a week?  
\_\_\_\_\_  
\_\_\_\_\_
12. What is the most you have weighed? \_\_\_\_\_
13. What do you think your ideal weight is \_\_\_\_\_
14. When was your last appointment with the eye doctor? \_\_\_\_\_  
Do you have any evidence of diabetes in your eyes (retinopathy)? \_\_\_\_\_
15. Do you have tingling and numbness in your feet (diabetic neuropathy)? \_\_\_\_\_



## SOCIAL HISTORY

1. Current work status \_\_\_\_\_ Occupation: \_\_\_\_\_
  2. Marital Status:      Single      Married      Divorced      Widowed
  3. Number of Children: \_\_\_\_\_
  4. I live: Alone    With: \_\_\_\_\_      I live in a:    House    Apartment    Nursing Facility
  5. Are you a cigarette smoker?    No    Yes    How old were you when you began smoking? \_\_\_\_\_  
     How much do you smoke daily? \_\_\_\_\_    When did you quit smoking? \_\_\_\_\_
  6. Do you drink any alcoholic beverages: (check one)    No    Yes  
     1   2   3   4   5   6   drinks   daily   weekly   monthly   social use only
  7. Have you ever had a problem with drug dependence?      Yes    No
  8. Please write any additional information that you feel is important for us to know.
- 
- 

## REVIEW OF SYTEMS

**Do you currently have any of the following medical symptoms?**

**General**

- Unexplained weight loss
- Appetite change
- Fevers or chills
- Night sweats
- Marked fatigue
- Difficulty sleeping

**Eyes**

- Glasses
- Change in vision
- Double vision

**Ear, Nose, Throat**

- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Ear pain
- Nosebleeds

**Cardiovascular**

- Heart or chest pain
- Abnormal heartbeat
- Leg swelling

**Respiratory**

- Morning cough
- Shortness of breath
- Productive cough or sputum

**Digestive**

- Nausea or vomiting
- Stomach pain or ulcers
- Heart burn
- Diarrhea
- Constipation
- Uncontrolled loss of stool
- Blood in stools

**Skin**

- Rashes
- Itchiness
- Easy bruising

**Neurological**

- Seizures
- Blackouts/fainting
- Headaches/migraines

**Musculoskeletal**

- Joint pains
- Joint swelling
- Numbness in feet/hands
- Muscle weakness

**Genitourinary**

- Burning on urination
- Incontinence
- Pelvic pain
- Impotence
- Abnormal Bleeding

**Psychiatric**

- Depression
- Anxiety
- Paranoia

**Other**

---



---



---



---