



Welcome to Endocrine & Diabetes Clinic!

It is our mission to serve as your leader and premier provider of endocrine and diabetes related medical services by continually learning, growing, and partnering with you, our patients, as well as our employees and other healthcare providers. As we strive to achieve excellence on a daily basis, it is our commitment to provide you with the highest level of quality and personal and compassionate care.

Enclosed you will find detailed documents and forms which outline our policies as well as other information important for your visit. If you have questions, please contact us prior to your appointment. Please take a few moments to complete these forms and bring them to your first visit.

Our practice follows certain guidelines and recommendations with which we ask to you become familiar.

- Please arrive 15 minutes prior to your scheduled appointment time in order to complete and/or review required paperwork. You may be asked to reschedule your appointment if you arrive more than 15 minutes later than your scheduled appointment time.
- Please bring all of your insurance cards, prescription cards, and photo ID with you to each scheduled appointment and notify us if your insurance should change.
- We will collect your co-payment, deductible, and/or past due balances prior to your visit with the provider. We accept cash, check, or credit card. Failure to make appropriate payments may result in having to reschedule your appointment.
- We will file all claims with your insurance carrier as appropriate and work with both you and your carrier to process these as quickly and accurately as possible. Patients are responsible to verify that their insurance is in-network with our providers and that any necessary prior authorization has been obtained from their insurance carrier. Patients may be responsible for payment of services not covered or paid by their insurance.
- Regular office hours are Monday through Thursday 8:00 am to 4:30 pm and Friday 8:00 am to 3:30 pm. Please request prescription refills during your office visit or call your pharmacy directly to request a refill. Routine medication refills are processed during office hours and are not processed at night or on weekends. When calling the clinic about a prescription or refill, please provide your pharmacy's name and phone number.
- Calls for the nurse or physician are returned as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please give us the best phone number and available times for returning your call.
- Please allow us up to two weeks to contact you regarding lab/test results or as otherwise communicated by the provider or nurse

We appreciate your consideration and patience in assisting us to better serve you.

ENDOCRINE & DIABETES CLINIC, PLLC.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO OBTAIN THIS INFORMATION. PLEASE REVIEW CAREFULLY. YOU HAVE THE RIGHT TO OBTAIN A COPY OF THIS NOTICE UPON REQUEST.

Patient Health Information

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We are permitted to use and disclose patient health information for treatment, payment, and healthcare operations.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other healthcare providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Healthcare Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality treatment, and to assess the care and outcome of your case and others similar to it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use and disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information about you for the following purposes.

Required by Law: We are required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent serious threat to the health and safety of your, another person, or the public.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Research: We may use or disclose information for approved medical research.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

Uses and Disclosures that Require Patient Authorization

In other situations, we will require your written authorization before using or disclosing your identifiable health information, which may include the following: disclosures to life insurance companies; non court ordered subpoenas; disclosures for non-authorized research purposes; disclosures to employers; copies of medical records to patient or other patient representative; marketing; disclosing any psychotherapy notes; or disclosing information in exchange for remuneration. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Revocation requests must be made in writing and submitted to the clinic's Privacy Officer.

You have the following rights with regard to your health information. Please contact our office to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to all such restrictions, but if we do agree, we must abide by them. You have the right to opt out of fundraising communications. Additionally, you have the right to restrict disclosure of personal health information related to services for which you have paid out of pocket.

Confidential Communications: You may ask us to communicate confidentially by, for example, sending notices to a special address or not calling with appointment reminders.

Inspect and Obtain Copies: In most cases, you have the right to look or obtain a copy of your health information. There may be a charge for the copies:

Amend Information: If you believe that information in your record is incorrect or that important information is missing, you have the right to request that we correct the existing information or add the missing information. We are not required to agree to such amendment, but must let you know our reasons.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Notice of Breach: You have the right to be notified in the event there is a breach of your identifiable health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, to notify you following a breach of your protected health information (unless your information was encrypted or otherwise rendered unreadable or unusable) and to abide by the terms of the Notice currently in effect. Upon request, you may receive a copy of this notice.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You may also request a copy of our Notice at any time. For more information about our privacy practices, contact our Privacy Officer.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we have made about your records, please contact our Privacy Officer. You may also send a written complaint to the U.S. Department of Health and Human Services. The Privacy Officer will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person / Privacy Officer

If you have any questions, complaints, or requests, please contact:

Tracey Wren-Cox, Practice Director
290 S Walnut Bend
Cordova, TN 38018
(901) 266-1080

This Notice became effective June 18, 2007, and was revised on August 10, 2015



M. Nauman Qureshi, MD
 Rabia A. Rehman, MD, FACE
 Casie F. Coats, DNP, FNP-C
 Laurie Raffety, MSN, FNP-C
 Katherine Forsdick, DNP, FNP-C

Date:

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Last Name	First Name	Middle Name	Preferred Name
Date of Birth	Social Security Number		Sex
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Primary Language
Race (Optional)	<input type="checkbox"/> Caucasian <input type="checkbox"/> Black / African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American / Alaskan Native		
Ethnicity (Optional)	<input type="checkbox"/> Non Hispanic / Latino <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Other: _____		
Street Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	
Email Address (for patient portal access)	Is it okay to leave a message at: Home Y / N Cell Y / N Work Y / N		
Employer	Occupation	Preferred Method of Communication: Home / Cell / Email / Text / US Mail	

PHYSICIAN REFERRAL / PHARMACY INFORMATION

Primary Care Physician	Referring Physician
Preferred Pharmacy / Location	Pharmacy Phone Number

INSURANCE INFORMATION

Primary Insurance	Policy Number / Member ID	Group Number
Name of Insured	Relationship to Patient	
Secondary Insurance	Policy Number / Member ID	Group Number
Name of Insured	Relationship to Patient	
Tertiary Insurance	Policy Number / Member ID	Group Number
Name of Insured	Relationship to Patient	

EMERGENCY CONTACT(S)

Name	Relationship	Phone Number	<input type="checkbox"/> May discuss health information <input type="checkbox"/> Leave message with call back # only
Name	Relationship	Phone Number	<input type="checkbox"/> May discuss health information <input type="checkbox"/> Leave message with call back # only
Name	Relationship	Phone Number	<input type="checkbox"/> May discuss health information <input type="checkbox"/> Leave message with call back # only

RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received or reviewed a copy of EDC's Notice of Privacy Practices as required by HIPAA. This notice describes how EDC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Initial _____

PARTICIPATION IN TENNCARE, MEDICAID, AND HEALTHCARE EXCHANGE PLANS

- EDC does currently participate in BlueCare but DOES NOT participate in any other TennCare or Medicaid plans. EDC DOES NOT participate in the BlueCross BlueShield Network E or Advantage HMO plans. If EDC is not contracted with your plan, please contact your insurance plan to determine an appropriate in-network provider for your medical services.

DISCLOSURE OF TENNCARE/ MEDICAID COVERAGE

- By initialing you are certifying one of the following: NO, I do NOT have active or pending TennCare or Medicaid coverage
 YES, I DO have active or pending TennCare or Medicaid coverage

Initial _____

APPOINTMENT CANCELLATION POLICY

- EDC requires a 24 hour cancellation notice for any scheduled medical appointment or surgery/procedure.
- No shows and cancellations without a 24-hour notice may receive a \$35.00 charge for missed office visits.
- This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.
- If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.

Initial _____

PATIENT PAYMENT POLICY AND COVERED SERVICES

- It is the policy of EDC to collect all patients balances, co-pays, deductibles, and/or co-insurance due from patients at the time of service.
- Our office may contact your insurance carrier to verify your insurance coverage and benefits. Our staff will make their best effort to determine or estimate your financial responsibility according to the contractual agreement between EDC and your insurance company for these services.
- If your insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for your services, and payment in full will be due immediately.
- If your account or any account for which you are responsible is sent to a collection agency due to non-payment of any patient balance, you may be dismissed from EDC for any future care and services, which includes all providers at EDC. Additionally, you will be responsible to pay for the collection agency fees (up to 35% of unpaid balance) and any attorney fees associated with the collection of your account.
- Your health insurance plan may not provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for your treatment. It is your responsibility to know and understand the services covered by your insurance, and if your insurance does not cover these services, you will be responsible for payment.
- If you do not have medical coverage and insurance through a carrier with which EDC participates, or if you are a new patient and cannot supply your valid insurance card, or if your coverage cannot be determined, you must pay in full at the time of service.
- Certain labs collected in this office may be sent to an outside lab for testing. As such, you may be billed by that reference lab for these.
- Please verify that any referral or prior authorization has been obtained prior to receiving additional medical services.

Initial _____

RETURNED CHECK CHARGE

- EDC will charge the patient account \$25.00 for any returned checks to cover EDC's cost for any related bank charges.

Initial _____

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

- By signing below, you authorize this office to release your protected health information (PHI), including account status, test results, scheduled appointments, and information regarding your treatment of the persons (in addition to the patient) you have listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Any person who is not listed above will not be able to obtain your protected health information. It is not necessary to list other treating physicians, insurance carriers or other covered entities. This Authorization is valid and effective (Endocrine & Diabetes Clinic) for a 5 year period/duration from initial date of service.

Patient Signature: _____ Date: _____

PERSONAL INFORMATION VERIFICATION

- As it is our policy to verify your demographic and insurance information at every visit to help insure that claims are processed timely and accurately, please bring your insurance card with you to every visit.
- Additionally, a photo ID will be requested from all patients.

Initial _____

PERSONAL INFORMATION VERIFICATION

- There is a minimum fee of \$20.00 for the release of medical records which is the responsibility of the patient to pay prior to receiving the records. For records that exceed twenty (20) pages, there may be an additional charge of \$0.50 per page for all pages exceeding the first twenty (20) pages. A \$20.00 fee will be charged to complete up two (2) forms for FMLA and standard disability. An additional fee of \$25.00 will be charged for submitting subsequent forms.

Initial _____

Patient Signature _____ Patient Printed Name _____

Date _____ Patient Chart # _____ EDC Initials _____

SIGNATURE SECTION

To the best of my knowledge, the information on the registration form is complete and correct. I understand that it is my responsibility to inform my doctor and his staff if there is a change in health, insurance and/or contact information.

Patient Signature: _____

Date: _____

CONSENT TO TREATMENT

I voluntarily consent to medical care at **Consolidated Medical Practices of Memphis** for routine diagnostic examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracing and administration of medications prescribed by the physician.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff and their assistants, including nurse practitioners, physician's assistants, medical assistants or their designees as necessary in the medical staff's judgment. This consent is valid and remains in effect as long as I receive medical care at **Consolidated Medical Practices of Memphis**.

I promise as a patient of **Consolidated Medical Practices of Memphis** that I will follow all office policy that pertain to the patients of the office. I understand that if I am not compliant with following the physicians' plan of care, I can be terminated from the practice. By signing this I agree to follow the plan of care to the best of my ability.

Patient Signature: _____

Date: _____

PRIVACY STATEMENT

We consider any information that concerns your health, health care, or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers, and independent contractors to comply with these privacy practices. We are required by federal law to obtain an acknowledgment from you that you received this notice.

Patient Signature: _____

Date: _____

BENEFIT AUTHORIZATION

- (a) I authorize **Consolidated Medical Practices of Memphis** to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my medical care.
- (b) I also request that payments of authorized benefits be made to me or on my behalf to **Consolidated Medical Practices of Memphis** for services rendered.
- (c) I further authorize the release of medical information about treatment here to my doctor or anyone designated by me.
- (d) I authorize the use of my signature on all insurance submissions.
- (e) I understand I am responsible for payment of all medical expenses incurred due to services rendered at the time of service.
- (f) I agree to provide complete and accurate information about all insurance policies that I participate in and advise the doctor and staff for any changes.

Patient Signature: _____

Date: _____

RELEASE OF INFORMATION DESIGNATION

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding insurance and billing concerns.

Name: _____ Phone #: _____ Relationship: _____

I authorize physicians and staff of **Consolidated Medical Practices of Memphis** to speak with the following people regarding my health care, plan of treatment, medications, and lab/test results.

Name: _____ Phone #: _____ Relationship: _____

ACCOUNT COLLECTIONS AGREEMENT

In the event that your account is placed with a Collection Agency, a collection-fee of up to 33.3% may be added to your account and shall become a part of the Total Amount Due. In the event your account is placed with an Attorney, you will be responsible for the reasonable Attorney fees and court cost.

You agree, that in order for us to service your account or to collect any amounts you may owe we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Patient Signature: _____

Date: _____

Clinical History Form

Medication															
<i>Please list all prescription and non-prescription medications, including nutritional supplements you currently take.</i>															
Medication			Dosage & Frequency			Medication			Dosage & Frequency						
Allergies															
<i>List all prescription and non-prescription medications to which you have had a reaction and describe the reaction.</i>															
Drug			Reaction			Drug			Reaction						
Review of Systems															
General		Y	N	Neck		Y	N	Cardiovascular		Y	N	Genitourinary		Y	N
Weight Loss				Neck/ Throat Pain				Chest Pain				Urination at Night			
Weight Gain				Neck Swelling				Palpitations				Excess Urination			
Fever				Hoarseness				Ankle Swelling/Edema				Blood in Urine			
Night Sweats				Sore Throat				Dyspnea on Exertion				Decreased Libido			
Fatigue				Trouble Swallowing				Calf Pain on Walking				Erectile Problem			
Difficulty Sleeping				Other				Other				Incontinence			
Endocrine				Respiratory				Musculoskeletal				Neurologic			
Intolerance to Heat				Difficulty Breathing				Back Pain				Headache			
Intolerance to Cold				Cough				Knee Pain				Dizziness			
Excessive Thirst				Bloody Sputum				Other Joint Pain				Head Spinning			
Excess Body Hair				Snoring				Diffuse Joint Pain				Fainting			
Abnormal Bruising				Gastrointestinal				Muscle Aches				Limb Weakness			
Excessive Sweating				Changes in Appetite				Skin				Tingling			
Irregular Menses				Acid Reflux				Itching				Numbness			
Vision, Hearing				Nausea				Dry Skin				Tremors			
Lack of Smell				Vomiting				Rash				Psych			
Decreased Hearing				Abdominal Pain				Hair Loss				Anxiety			
Ringing in the Ears				Diarrhea				Brittle Flaking Nails				Depression			
Eyesight Problem				Constipation				Dry Brittle Hair				Mood Swings			
Double Vision				Blood in Stools				Other				Other			

Clinical History Form

Tobacco Use History			
<input type="checkbox"/> I currently smoke cigarettes	I have a plan to quit. I agree <input type="checkbox"/> Completely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not Really <input type="checkbox"/> Not at All		
Number of Packs/Day:	Number of Years:	Comments:	
<input type="checkbox"/> I have quit smoking	Quit Date:	How many years did you smoke before quitting?	
How many packs/day did you use to smoke?		Comments:	
<input type="checkbox"/> I live with household members who smoke	I use other forms of tobacco: <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar <input type="checkbox"/> Snuff <input type="checkbox"/> Chew		
<input type="checkbox"/> I have never smoked	<input type="checkbox"/> I have smoked, but rarely	Please Explain:	
Drug and Alcohol Use History			
Have you ever used recreational drugs or needles? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list what type:	
Describe how long and method of use:			
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Drinks/Week:	Is alcohol use a concern for you or others? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Socioeconomic History			
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is your occupation?	
Work Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Student			
Education Completed: <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School			
Number of Children:		Number of Household Members:	
Whom do you live with? <input type="checkbox"/> Parents <input type="checkbox"/> Spouse/SO <input type="checkbox"/> Children <input type="checkbox"/> Other Relatives <input type="checkbox"/> Other Non-Relatives			

Past Medical History							
Endocrine	Y	Rheum / Renal	Y	Cardiovascular	Y	GI / Respiratory	Y
Diabetes Type 1		Rheumatoid Arthritis		Heart Attack		Reflux GERD	
Diabetes Type 2		Lupus		Angina (Chest Pain)		Celiac Disease	
High Cholesterol		Osteoarthritis		Heart Disease		Stomach Ulcers	
Hypertension		Gout		CHF		Hepatitis	
Hyperthyroidism		Fibromyalgia		Atrial Fibrillation		Fatty Liver	
Hypothyroidism		Sleep Apnea		PVD		NASH	
Goiter		Kidney Stones		Carotid Stenosis		Cirrhosis	
Calcium Disorder		Kidney Disorder		DVT		Pancreatitis	
Pituitary Disorder		Glaucoma		Neurological		Diverticulosis	
Osteoporosis		Psych / Misc		Migraine Headaches		Cancer	
PCOS		COPD		Stroke		Breast	
Erectile Dysfunction		Asthma		Seizures		Colon	
Vitamin D Deficiency		Anxiety		Dementia		Lung	
Bone Fracture		Depression		Neuropathy		Thyroid	
Family History				Surgical History			
<i>*Please list all family members with the following medical conditions:</i>				<i>*Please list all previous surgeries, approximate date and location:</i>			
Condition	Year	Relationship	Procedure	Year	Location		
Heart Attack			Carotid Stents / Surgery				
Hypertension			CABG				
High Cholesterol			Heart Stents				
Calcium Disorder			Pacreatectomy				
Cancer (Type):			Appendectomy				
Stroke			Cholecystectomy				
Diabetes Mellitus			Hernia Repair				
Osteoporosis			Thyroid Surgery				
Hyperthyroidism			Tonsillectomy				
Hypothyroidism			Hysterectomy				
Kidney Stones			Tubal Ligation				
Other:			Transsphenoidal Surgery				
Other:			Other:				
Hospitalizations / Other Illnesses							
<i>*Please list all previous hospitalizations and major illnesses, with dates and reasons:</i>							
Dates		Reason			Location		

Diabetes Health History Form

General			
In what year were you diagnosed with diabetes?		Whom were you diagnosed by?	
How was your diabetes treated initially? <input type="checkbox"/> Diet and Weight Loss <input type="checkbox"/> Oral Medications <input type="checkbox"/> Insulin <input type="checkbox"/> Other			
Please Explain:			
How was diagnoses made? <input type="checkbox"/> Elevated HbA1c <input type="checkbox"/> OGTT <input type="checkbox"/> Hospitalized <input type="checkbox"/> Not feeling well <input type="checkbox"/> Don't Know			
Please Explain:			
Have you had a recent measurement of your A1C? <input type="checkbox"/> Yes <input type="checkbox"/> No		Where was it done?	Value:
Medication Use History			
What Diabetes Medications have you used in the past, but are <u>not</u> currently taking?			
1)	2)	3)	4)
Why were these medications stopped? <input type="checkbox"/> Ineffective <input type="checkbox"/> Side Effects <input type="checkbox"/> Change of Plan <input type="checkbox"/> Other			
If Other Reasons, please explain:			
Current Insulin Injections			
Dosing	Insulin - (Humalog, Novolog, Apidra, Lantus, Levemir, NPH, U 500, Other)		Dosage - (*List the Range of Units Given Before Meals)
Early Morning			
Breakfast			
Lunch			
Dinner			
Bedtime			
* Correction Scale-Please describe how you cover a high blood glucose:			
If you use insulin vials, who fills the syringe? <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Significant Other <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Parent <input type="checkbox"/> Other			
What injection sites are used? <input type="checkbox"/> Stomach <input type="checkbox"/> Arm <input type="checkbox"/> Thigh <input type="checkbox"/> Hip <input type="checkbox"/> Buttock <input type="checkbox"/> Other			
Do you rotate your injection site? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you reuse your syringes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often?	
Where do you dispose of your syringes?		Do you have infections at the injection site? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How often do you forget or miss an insulin injection each day? <input type="checkbox"/> 1x/day <input type="checkbox"/> 2x/day <input type="checkbox"/> 3x/day <input type="checkbox"/> 1-2x/week			
Which insulin dose are you most likely to miss? <input type="checkbox"/> Basal <input type="checkbox"/> Mealtime <input type="checkbox"/> Don't know			
What are you typically doing at the time you are likely to miss an injection?:			

Diabetes Health History Form

Blood Sugar Testing	
Do you have a glucometer (blood sugar testing device)? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the Name or Brand?
Do you test yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many times a day do you test? <input type="checkbox"/> 1-2 <input type="checkbox"/> 3+ <input type="checkbox"/> Few times/wk <input type="checkbox"/> Rarely
What target range do you try to keep your blood sugars between?	
What are your usual fasting blood sugars? <input type="checkbox"/> 70-120 <input type="checkbox"/> 120-150 <input type="checkbox"/> 150-200 <input type="checkbox"/> >200	
What are your usual post meal blood sugars? <input type="checkbox"/> 80-150 <input type="checkbox"/> 150-200 <input type="checkbox"/> 200-300 <input type="checkbox"/> >300	
How would you rate your control over the years? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Not Sure	
Please Explain:	
How would you rate your control over the past few weeks? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Not Sure	
Hypoglycemia	
What do you consider a low blood sugar?	How often do you have low blood sugar, below 70?
<input type="checkbox"/> Daily <input type="checkbox"/> Few times/week <input type="checkbox"/> Once/week <input type="checkbox"/> Few times/month <input type="checkbox"/> Once in a while <input type="checkbox"/> Never <input type="checkbox"/> Not Sure	
Do you feel different when your blood sugar is low? (Check all that apply)	
<input type="checkbox"/> Sweaty <input type="checkbox"/> Shaky <input type="checkbox"/> Hungry <input type="checkbox"/> Weak <input type="checkbox"/> Pale <input type="checkbox"/> Dizzy <input type="checkbox"/> Irritable <input type="checkbox"/> Trouble Concentrating	
When is a low blood sugar most likely to occur? <input type="checkbox"/> Morning <input type="checkbox"/> After exercise <input type="checkbox"/> After a missed meal <input type="checkbox"/> Not Sure	
How do you treat a low blood sugar that occurs? (Check all that apply) <input type="checkbox"/> Adjust medicine dose <input type="checkbox"/> Skip medicine	
<input type="checkbox"/> Adjust Physical Activity <input type="checkbox"/> Adjust Carb/Food intake <input type="checkbox"/> Check Sugars More Often <input type="checkbox"/> Call Healthcare provider	
Have you ever had extremely low blood sugars causing unconsciousness? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:	
Complications	
Have you had any hospitalizations for high sugar or DKA since diagnoses? <input type="checkbox"/> Yes <input type="checkbox"/> No	When?
Have you ever had diabetic eye disease or previous laser treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider:
When was your last dilated eye exam?	Where was it performed?
Have you ever had kidney problems or protein in your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Have you ever been diagnosed with diabetic neuropathy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Have you ever seen a foot doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a foot sore or ulcer debrided? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken steroid medications in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pills <input type="checkbox"/> Injections <input type="checkbox"/> Inhalers <input type="checkbox"/> Creams <input type="checkbox"/> Other
Do you take aspirin daily? <input type="checkbox"/> Yes <input type="checkbox"/> No Dose:	Have you had a flu shot during this flu season? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had the Pneumonia Vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:	Comments:



Patient Health Questionnaire

* Please complete and return to your nurse. *

Patient Name: _____ DOB: _____ Date: _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Depression Screening (PHQ-9)	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little Interest or pleasure in doing things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, hopeless.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Trouble falling/staying asleep, sleeping too much.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling tired or having little energy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Poor appetite or overeating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Trouble concentrating on things such as reading the newspaper or watching TV.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Moving or speaking so slowly that other people have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

_____ + _____ + _____ + _____
 = _____

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?

- Not difficult at all Somewhat Difficult Very Difficult Extremely Difficult

Have you fallen within the last 12 months? YES / NO If so, when and how? _____

Do you use tobacco? YES / NO / FORMER How long? _____ Amount? _____

Date of last Flu Vaccine? _____ Who gave your last Flu Vaccine? _____

Have you had a Pneumonia Vaccine ? YES / NO If so, when? _____

When was your last mammogram? _____ Where was it? _____

When was your last colonoscopy? _____ When is your next colonoscopy due? _____

Date of Last Eye Exam? _____