Comanche County Memorial Hospital
Lawton, Oklahoma 73505

Place Patient Sticker Here

Diabetes Center
NEW PATIENT FORM

This information is important and will be used in our visit today. Please fill out both sides the best you can.

Daytime phone contact ☐ Home ☐ Work ☐ Cell _____ ☐ Message phone _____

Race: Caucasian / African Amer. / Native Amer. Indian / Hispanic / Asian Amer. / Other _____

* Age: _____ Height: _____ Weight: _____ Lowest adult weight: _____ Recent weight loss: _____

* Do you have any family members with diabetes? _____

* If pregnant, pre pregnancy weight? _____ If pregnant are you planning on breastfeeding? _____

Please rate your ability to:	Poor	Fair	Good	Excellent	Unknown
Make changes	0	1	2	3	☐
Managing your diabetes when you are sick	0	1	2	3	☐
Managing your diabetes overall	0	1	2	3	☐
Improve your risk factors for complications	0	1	2	3	☐
Manage stress in your life	0	1	2	3	☐
Control your blood glucose	0	1	2	3	☐
Control your blood pressure	0	1	2	3	☐

Please check any of the following conditions or symptoms you have along with your diabetes:

__ Skin problems

__ vision changes or problems

__ kidney problems

__ foot problems

__ burning pain or numbness in feet or legs (neuropathy)

__ high triglycerides or cholesterol

__ heart problems
__ open heart surgery
__ stents
__ high blood pressure

__ sexual problems

__ problems with teeth gums or swallowing

__ frequent hypoglycemia (low blood sugars)

__ (please circle which ones) constipation, diarrhea nausea, vomiting, bloating

___ dizziness or swimming in head when standing up quickly

___ frequent infections (describe)

__ other _____

Have you been in the hospital or ER for diabetes problems? Yes No When _____

* Why: _____

* How often do you see your doctor? _____ * How often do you see your dentist? _____

* When was your last dilated eye exam? _____

* How do you rate your general health overall? Poor Fair Good Excellent

* Do you exercise now? _____ Yes _____ No

If yes, what do you do? _____

How frequently? Times per week _____ How long _____

Do you have any limitations on exercise? _____ Yes _____ No

If yes, please describe _____

* How often do you do these self-care skills each day?

Check your blood sugar each day	0	1	2	3	4	5	6	7	8
Take medications	0	1	2	3	4	5	6	7	8
Check your feet for problems	0	1	2	3	4	5	6	7	8
Check your nails for problems	0	1	2	3	4	5	6	7	8

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* How many times do you do the following?

How many meals per day _____
Eat meals at specific times each day _____
How many snacks/day _____
How many low blood sugars / week _____
Drink alcohol beer, wine / week _____

Do you smoke? Yes No
If yes-how many packs per day _____
I quit ____ How long ago did you quit? _____
How much were you smoking? _____
How many times do you eat out? _____

Are there any food/beverages which you cannot tolerate? Please list: _____

Do you have any food allergies? If so, please list: _____

* How often do you eat the following foods per day?

Milk	_____	Candy/Chocolate	_____	Ethnic Foods	_____
Fruit	_____	Baked goods	_____	Alcohol	_____
Vegetables	_____	Desserts	_____	Coffee / tea	_____
Juice	_____	Ice cream	_____	Artificial sweeteners	_____
Snack foods	_____	Soda Pop - Reg. / Diet	_____		

* Do any of the following affect your choice of foods?

Finances	Yes	No	Grocery shopping	Yes	No
Activity	Yes	No	Meal preparation	Yes	No
Eating out	Yes	No	Other food restrictions/allergies	Yes	No
Eating Disorder	Yes	No	Breastfeeding	Yes	No
Occupation	Yes	No	Prescription Drugs	Yes	No
Shift work	Yes	No	Alcohol / Other	Yes	No
Eating in response to stress	Yes	No	Vitamins	Yes	No
			Herbal supplements	Yes	No

Prescription Medication

* What medication do you take? (including diabetes pills or insulin)

Name:	Dose:	Time Taken:

Over the counter medication, vitamin / herbs / mineral supplement

Reviewed by: _____ Date/Time: _____

Bring this completed Form to your appointment

3 DAY FOOD RECORD

Write down everything you eat and drink with portion sizes (Ex. Skim milk 8 oz. ½ cup pineapple)

DAY 1	DAY 2	DAY 3
BREAKFAST TIME:_____	BREAKFAST TIME:_____	BREAKFAST TIME:_____
SNACK TIME:_____	SNACK TIME:_____	SNACK TIME:_____
LUNCH TIME:_____	LUNCH TIME:_____	LUNCH TIME:_____
SNACK TIME:_____	SNACK TIME:_____	SNACK TIME:_____
DINNER TIME:_____	DINNER TIME:_____	DINNER TIME:_____
SNACK TIME:_____	SNACK TIME:_____	SNACK TIME:_____