DIABETES & ENDOCRINE WELLNESS CENTER, LLC

(Please select **ALL** you have experienced since your last visit)

PATIENT NAME: _____DOB:_____DATE: _____

GENERAL

Weakness	☐YES	☐NO
Hair Loss	☐YES	☐NO
Headache	☐YES	☐NO
Fever	☐YES	☐NO
Weight Gain	☐YES	☐NO
Weight Loss	☐YES	☐NO
Fatigue	☐YES	☐NO
Loss of Appetite	☐YES	☐NO
Difficulty with Sleep	☐YES	☐NO

EYES

Cataracts	☐YES	☐NO
Bulging Eyes	☐YES	☐NO
Laser Treatment	☐YES	☐NO
Glaucoma	☐YES	☐NO
Blurry Vision	☐YES	☐NO
Loss of Vision	☐YES	☐NO
Double Vision	☐YES	☐NO

ENT/THYROID

Change of Voice	☐YES	☐NO
Difficulty in Swallowing	☐YES	☐NO
Swelling in the Neck	☐YES	☐NO

ENDOCRINE

Frequent Urination at Night	☐YES	☐NO
Cold Intolerance	☐YES	☐NO
Breast Discharge	☐YES	☐NO
Increase in Size of Hands or Feet	☐YES	☐NO
Excessive Thirst	☐YES	☐NO
Heat Intolerance	☐YES	☐NO

RESPIRATORY

Cough	☐YES	☐NO
Shortness of Breath	☐YES	☐NO

GI SYSTEM

Stomach Pain	☐YES	☐NO
Constipation	☐YES	☐NO
Diarrhea	☐YES	☐NO
Nausea	☐YES	☐NO
Vomiting	☐YES	☐NO

CARDIOVASCULAR

Chest Pain	☐YES	☐NO
Palpitations	☐YES	☐NO

BLOOD

Women: Heavy Menstrual Periods	☐YES	☐NO
Easy Bruising	☐YES	☐NO

GENITOURINARY

Decreased Sexual Desire	☐YES	☐NO
Men: Erectile Dysfunction	☐YES	☐NO
Women: Absent Menstrual Periods	☐YES	☐NO

Date of Last Menstrual Period _____

MUSCULOSKELETAL

Fractures as an Adult	☐YES	☐NO
Muscle Weakness	☐YES	☐NO

SKIN/NAILS

Brittle Nails	☐YES	☐NO
Dry Skin	☐YES	☐NO

NEUROLOGIC

Burning	☐YES	☐NO
Numbness	☐YES	☐NO
Tingling	☐YES	☐NO

PSYCHIATRIC

Anxiety	☐YES	☐NO
Depression	☐YES	☐NO

MEDICAL QUESTIONS:

I exercise _____ number of times a week by:

Elliptical Gardening **Jog** Treadmill
Water Sports Walk **Yoga**
Other _____

SCREENING: (Month and Year of Last Exam)

My last eye exam was in the last 12 months ☐YES ☐NO

My last foot exam was in the last 12 months ☐YES ☐NO

Foot: _____ Eye: _____

I would like to be addressed by:

☐**My First name** ☐**Mr. Last Name**

☐**Ms. Last Name** ☐**Dr. Last Name**