RESTOR METABOLIX℠ ASHEVILLE

NEW PATIENT CONSULTATION FORM

Confidentiality Notice: Please note that this form is part of the confidential medical record and will be kept in your Clinic Name file. Information contained here will not be released to any person except under your authorization.

Name: _____ Preferred Name: _____
Date of Birth: _____
In brief, what main concern(s) and/or interest(s) bring you to our office? _____
_____

SOCIAL HISTORY

Marital Status (*circle one*): Single Married Divorced Widowed

Number of children: _____ **Race or Ethnicity**: _____

Females (*circle*): Are you Pregnant? Nursing? Planning pregnancy?

Date of Last Menstrual Period: _____

Occupation (if retired, previous occupation): _____

Smoking Have you ever smoked? (*circle*): Yes No
If Yes, what age did you start? _____ How many cigarettes per day? _____
Have you tried to quit? _____ If successful, what age did you quit? _____

Alcohol Do you drink any alcohol? (*circle*): Yes No
If Yes, how much (# of drinks per day, month, or year)? _____
If so, what type of alcohol? (*circle all that apply*): Wine Beer Liquor

Recreational Drugs Have you ever used recreational drugs? (*circle*): Yes No
If Yes, which ones & when was the last date of use? _____

MEDICAL HISTORY

Allergies (list any allergy to drug, latex, and/or food): _____

Medications (list all medications--with dosages--you regularly take, including over-the-counter, herbal, and natural remedies. If you are on **insulin**, please clarify administration method, whether vials, pens, or pump):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pharmacy:

Name:
_____

Address:
_____

_____

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Medical Conditions:
Please ***circle*** diagnosed medical conditions, write date of each diagnosis, and if applicable include further details.

Diagnosis	Date of Diagnosis	Details
Diabetes *Circle one*: Type 1 Type 2 Gestational Unknown		
Pre-Diabetes		
High Blood Pressure		
High Cholesterol		
Heart Murmur		
Heart Attack(s)		
Stroke(s)		
Thyroid Disorder *Circle*: Hyperthyroidism Hypothyroidism Thyroid nodule(s) Other		
Liver Disease *Circle:* Hepatitis Fatty Liver Other		
Kidney Issues *Circle:* Kidney Stones Chronic Kidney Disease On Dialysis Other		
Gastrointestinal Problems *Circle:* Gastroparesis Acid Reflux Diverticulitis Other		
Eye Disease *Circle:* Cataracts Glaucoma Retinopathy Other		
Reproductive Issues *Circle:* Erectile Dysfunction Prostate Enlargement Infertility Other		
Vitamin Deficiencies *Circle:* Low Vitamin D Low Vitamin B12 Low Magnesium Other		

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Psychological Diagnosis *Circle:* Depression Anxiety Bipolar Disorder Other		
Anemia *Specify type if known:*		
Cancer *Specify type if known:*		
Other Conditions: _____ _____ _____		

Surgical History:
Please list prior surgeries and an accompanying date or year, if known.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History:
Please list family health information if known, with emphasis on significant, chronic conditions.

Family Member	**If deceased, age at death**	**Significant Health Issues** (especially any diabetes, heart disease, stroke, cancer)
Father		
Mother		
Brother(s)		
Sister(s)		
Grandparent(s)		

Diabetes-specific Health Information:
Free text or circle your answers as designated. For some, note that **Y** indicates "Yes" & **N** indicates "No."

1) What was your most recent HgbA1c? _____%
2) Have you been hospitalized in the last 12 months related to diabetes (*circle*)? **Y** **N**

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3) Do you have any of the following diabetes-related complications? (*circle*- a, b, c)
   a. Neuropathy (nerve damage). If yes, do you clarify symptoms/diagnosis:
      i. When were you diagnosed? _____
      ii. Numbness/tingling in hands? **Y** **N**
      iii. Numbness/tingling in feet? **Y** **N**
      iv. Pain in hands? **Y** **N**
      v. Pain in feet? **Y** **N**
   b. Retinopathy (bleeding behind your eyes)
      i. When was your last eye exam? _____
      ii. Do you wear (*circle*) glasses? _____ contacts? _____
      iii. Have you received any eye injections? **Y** **N** When? _____
   c. Kidney dysfunction
      i. Have you ever been referred to a kidney doctor? **Y** **N**
      ii. Are you on (*circle*) hemodialysis? peritoneal dialysis?
      iii.
4) How often do you check your blood sugar? _____
   a. How often is your have blood sugar below 80 mg/dL? _____
   b. If known, what does your blood sugar range at the following times?
      i. on fasting (8 hours without eating)? _____
      ii. two hours after your largest carbohydrate meal? _____
      iii. at bedtime? _____
5) How many meals do you eat per day? _____ Do you snack at bedtime? **Y** **N**
6) Have you seen a dietician? **Y** **N**
7) Do you count carbohydrates? **Y** **N**
   a. If so, how many carbohydrates do you currently eat per day? _____ grams
8) Do you exercise? **Y** **N**
   a. If so, how many minutes per week on average? _____
   b. What type (e.g. yoga, weights, running, walking)? _____

SYMPTOM REVIEW

Please check current issues and symptoms, if a chronic concern or a recent significant change.

Constitutional:

- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats
- ☐ Sleep disruption
- ☐ Recent, significant weight change

Eyes and Ears:

- ☐ Wear glasses
- ☐ Wear contacts
- ☐ Blurred vision
- ☐ Double vision
- ☐ Photophobia
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Ear pain
- ☐ Hearing loss

Nose:

- ☐ Allergy or sinus problems
- ☐ Nosebleeds
- ☐ Nasal congestion
- ☐ Nasal discharge

Mouth and throat:

- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or taste

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- ☐ Sore throat
- ☐ Voice change
- ☐ Current, untreated dental problems
- ☐ Trouble swallowing

Cardiovascular:

- ☐ Chest pain
- ☐ Chest pressure
- ☐ Chest tightness
- ☐ Palpitations
- ☐ Dizziness

Respiratory:

- ☐ Chronic or frequent cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Hemorrhoids
- ☐ Heartburn
- ☐ Change in usual bowel pattern
- ☐ Blood in stool or vomit

Genitourinary:

- ☐ Blood in urine
- ☐ Painful urination
- ☐ Straining to urinate
- ☐ Increased frequency of urination
- ☐ Nighttime urination
- ☐ Leaking urine
- ☐ Sexual dysfunction

Musculoskeletal:

- ☐ Joint pain
- ☐ Neck pain
- ☐ Back pain
- ☐ Stiff joints
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Difficulty walking

Skin:

- ☐ Rashes
- ☐ Changes in skin color
- ☐ Change in hair or nails
- ☐ Leg swelling
- ☐ New lesion(s)

Neurological:

- ☐ Numbness
- ☐ Tingling sensation
- ☐ Complete loss of sensation
- ☐ Loss of balance
- ☐ Paralysis
- ☐ Frequent or severe headaches
- ☐ Convulsions or seizures
- ☐ Tremor

Psychosocial:

- ☐ Depression
- ☐ Memory loss
- ☐ Confusion
- ☐ Anxiety
- ☐ Suicidal thoughts

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Hematologic / Lymphatic:

- ☐ Trouble healing after cuts
- ☐ Excessive bleeding
- ☐ Excessive bruising
- ☐ Swollen lymph nodes

Endocrine:

- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst

Other Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____