costus
medical | pharmacy

NEW PATIENT INTAKE FORM

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

Name: _____ **Preferred Name:** _____ **DOB:** _____

In brief, what main concern(s) and/or interest(s) bring you to our office? _____

_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | **Number of Children:** _____

Females: Are you ☐ Pregnant? ☐ Nursing? ☐ Planning Pregnancy? | **Last Menstrual Period:** _____

Occupation (if retired, previous occupation): _____

Smoking: Have you ever smoked? ☐ YES ☐ NO | If yes, what age did you start? _____

How many cigarettes per day? _____ Have you tried to quit? ☐ YES ☐ NO

If successful, what age did you quit? _____

Alcohol: Do you drink alcohol? ☐ YES ☐ NO | If yes, how much (# of drinks per day, month, or year)? _____

If so, what type of alcohol? (check all that apply): ☐ Wine ☐ Beer ☐ Liquor

Recreational Drugs: Have you ever used recreational drugs? ☐ YES ☐ NO

If yes, which ones and when was the last date of use? _____

MEDICAL HISTORY

Allergies: (list any allergy to drugs, 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- vials, pens or pump):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

DIAGNOSIS	DATE AND DETAILS OF DIAGNOSIS
Diabetes ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Unknown	
Pre-Diabetes	
High Blood Pressure	
High Cholesterol	
Heart Murmur	
Heart Attack(s)	
Stroke(s)	
Thyroid Disorder ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Thyroid nodule(s) ☐ Other	
Liver Disease ☐ Hepatitis ☐ Fatty Liver ☐ Other	
Kidney Issues ☐ Kidney Stones ☐ Chronic Kidney Disease ☐ On Dialysis ☐ Other	

DIAGNOSIS	DATE AND DETAILS OF DIAGNOSIS
Gastrointestinal Problems ☐ Gastroparesis ☐ Acid Reflux ☐ Diverticulitis ☐ Other	
Eye Disease ☐ Cataracts ☐ Glaucoma ☐ Retinopathy ☐ Other	
Reproductive Issues ☐ Erectile Dysfunction ☐ Prostate Enlargement ☐ Infertility ☐ Other	
Vitamin Deficiencies ☐ Low Vitamin D ☐ Low Vitamin B12 ☐ Low Magnesium ☐ Other	
Psychological Diagnosis ☐ 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: Check your answers as designated.

1. What was your most recent HgbA1c? _____ %
2. Have you been hospitalized in the last 12 months related to diabetes? ☐ YES ☐ NO

Do you have any of the following diabetes-related complications? (Check - a, b, c)

☐ a. **Neuropathy** (nerve damage). If yes, do you clarify symptoms/diagnosis:

i. When were you diagnosed? _____

ii. Numbness/tingling in hands? ☐ YES ☐ NO

iii. Numbness/tingling in feet? ☐ YES ☐ NO

iv. Pain in hands? ☐ YES ☐ NO

v. Pain in feet? ☐ YES ☐ NO

☐ b. **Retinopathy** (Bleeding behind your eyes)

i. When was your last eye exam? _____

ii. Do you wear ☐ glasses? ☐ contacts?

iii. Have you received any eye injections? ☐ YES ☐ NO When? _____

☐ c. **Kidney Dysfunction**

i. Have you ever been referred to a kidney doctor? ☐ YES ☐ NO

ii. Are you on ☐ hemodialysis? ☐ peritoneal dialysis?

3. **How often do you check your blood sugar?** _____

a. How often do you have blood sugars below 80 mg/dL? _____

b. If known, what do your blood sugars range at the following times? _____

i. on fasting (8 hours without eating)? _____

ii. two hours after your largest carbohydrate meal? _____

iii. at bedtime? _____

4. **How many meals do you eat per day?** _____ Do you snack at bedtime? ☐ YES ☐ NO

5. **Have you seen a dietician?** ☐ YES ☐ NO

6. **Do you count carbohydrates?** ☐ YES ☐ NO

a. If so, how many carbohydrates do you currently eat per day? _____ grams

7. **Do you exercise?** ☐ YES ☐ NO

a. If so, how many minutes per week on average? _____

b. What type (e.g., yoga, weights, running, walking)? _____

SYSTEM REVIEW

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

Constitutional:

☐ Fever ☐ Chills ☐ Sleep disruption

☐ Fatigue ☐ Night sweats ☐ Recent, significant weight change

Eyes and Ears:

☐ Wear Glasses ☐ Photophobia ☐ Earaches

☐ Wear Contacts ☐ Eye Drainage ☐ Ear Pain

☐ Blurred Vision ☐ Eye Pain ☐ Hearing Loss

☐ Double Vision ☐ Ringing in Ears

Nose:

☐ Allergy or Sinus Problems ☐ Nosebleeds ☐ Nasal Congestion ☐ Nasal Discharge

Mouth and Throat:

☐ Mouth Sores ☐ Sore Throat ☐ Trouble Swallowing

☐ Bleeding Gums ☐ Voice Change

☐ Bad Breath or Taste ☐ Current, untreated dental problems

Cardiovascular:

- ☐ Chest Pain
- ☐ Chest Tightness
- ☐ Dizziness
- ☐ Chest Pressure
- ☐ Palpitations

Respiratory:

- ☐ Chronic or Frequent Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Gastrointestinal:

- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Change in Usual Bowel Pattern
- ☐ Vomiting
- ☐ Hemorrhoids
- ☐ Blood in Stool or Vomit
- ☐ Diarrhea
- ☐ Heartburn

Genitourinary:

- ☐ Blood in Urine
- ☐ Increased Frequency of Urination
- ☐ Sexual Dysfunction
- ☐ Painful Urination
- ☐ Nighttime Urination
- ☐ Straining to Urinate
- ☐ Leaking Urine

Musculoskeletal:

- ☐ Joint Pain
- ☐ Stiff Joints
- ☐ Difficulty Walking
- ☐ Neck Pain
- ☐ Muscle Weakness
- ☐ Back Pain
- ☐ Muscle Cramps

Skin:

- ☐ Rashes
- ☐ Change in Hair or Nails
- ☐ New Lesion(s)
- ☐ Changes in Skin Color
- ☐ Leg Swelling

Neurological:

- ☐ Numbness
- ☐ Loss of Balance
- ☐ Convulsions or Seizures
- ☐ Tingling Sensation
- ☐ Paralysis
- ☐ Tremors
- ☐ Complete Loss of Sensation
- ☐ Frequent or Severe Headaches

Psychosocial:

- ☐ Depression
- ☐ Confusion
- ☐ Suicidal Thoughts
- ☐ Memory Loss
- ☐ Anxiety

Hematologic/Lymphatic:

- ☐ Trouble Healing After Cuts
- ☐ Excessive Bruising
- ☐ Excessive Bleeding
- ☐ Swollen Lymph Nodes

Endocrine:

- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Excessive Thirst

Other Comments: _____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

Reviewed by: _____ **Date:** _____