New Patient Health History: Diabetes Education

CONFIDENTIAL CLIENT INFORMATION

Please print clearly

Date: / /

Surname …….. **Given Names** …….

Age …….. Date of Birth / / Sex M ❑ F ❑ Country of Birth ……..

Address ……

Phone (H) ……. (M) ……. (W) ……

Email ……

Medicare number …… Expiry Date …….

Reference number (next to your name on card) …….

Health Benefits

DVA card Gold ❑ White ❑ Private Health Fund ❑ ……

Usual General Practitioner …… Location …….

Reason for today's visit: ……

Type of Diabetes Type 1 ❑ Type 2 ❑ Not sure ❑ Other ❑ Year of diagnosis……

Does your have a family history of diabetes? Yes ❑ No ❑ Unknown ❑

Occupation ……. Hours per week ……..

Relationship Status (please circle) Single Divorced Married Widowed Separated Other

Do you live alone? Yes ❑ No ❑ If not who do you live with? .....

Do you have any home supports? .....

Do you have any pets? .....

What are your hobbies/things that inspire and fulfil you? .....

Any specific religious or cultural practices that are important to you?

……

……

Height …….. Current Weight …….

Would you like your weight to be different? If so, what? …….

Any major surgery? Please provide details

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……

……

Any illnesses/hospitalisations/injuries?

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……

Do you see any other therapists or other health care providers? Please list

……

Please list all medications or supplements you currently use

……

……

……

Do you have any allergies or sensitivities to medications, foods, herbs? Please list

……

Do you smoke? No ❑ Yes ❑ How many/day? ..... Ex-smoker ❑

Have you tried quitting? Yes ❑ No ❑ Do you want to give up? Yes ❑ No ❑

What have you tried? …….

Do you sleep well? Yes ❑ No ❑ How many hours? .....

Do you wake up at night? Yes ❑ No ❑ Reason …….

Have you had, or are you currently experiencing increased stress in your life? .....

Do you experience feeling down, depressed and find managing your health difficult at times? Please explain ……

……

……

How do you usually manage stress? ……

What do you do for relaxation? .....

Sports/Activity/Exercise How much each week? Specify type ……

Are you currently driving? Yes ❑ No ❑ Do you have any restrictions? .....

What is your usual food intake?

Breakfast ……..

Lunch ……..

Dinner …….

Snacks ……

Do you eat 3 meals/day? .....

How many glasses of water/day? ..... How many cups of tea or coffee/day? ……

If you add sugar or sweeteners, how much do you use per cup? .....

Do you drink alcohol? No ❑ Yes ❑ How many drinks per day? .....

What other fluids do you drink? Fruit Juices ❑ Sports drinks ❑ Other…….

Do you experience constipation/diarrhoea/abdominal pain/wind? Yes ❑ No ❑

If so, please explain ……..

Do you crave sugar and coffee? .....

The most important thing I would like to do to improve my health is

……

……..

……

……

……

For Clinical Use Only

Current HbA1c

Random BGL

Foot check

Weight

Self Blood Glucose monitoring?

Meter type

Blood Glucose diary

Registered with NDSS Yes ❑ No ❑

Optometrist

Podiatrist

Endocrinologist

Dentist

Other