PATIENT CONSENT AND AUTHORIZATION FOR TREATMENT

I, the undersigned am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Diabetes Care Group (DCG), through its individual physician's employees, and/or agents. Such care may include, but not be limited to, diagnostic procedures, other treatments and medications, and procedures considered advisable in my diagnosis, treatment, and course of care. I acknowledge that no guarantees can be made or have been made as to results of treatments or examinations at DCG.

Unless I tell you otherwise, I authorize DCG to send results from any diagnostic test to my Primary Care Physician (PCP) or regular professional health care provider or any other health care provider, practice, or facility. Any other specific medical questions I have about my or the patient's medical condition, treatment, care, or diagnosis should be presented to my PCP or regular professional health care provider. I acknowledge and agree that results from any diagnostic test will be sent to the address on my account.

In consideration of services provided by DCG, I hereby assign and transfer to DCG any and all rights, entitlement and interest in all benefits and payments now due and payable, or that become due and payable, under any insurance policies, any replacement policies, any self-insurance program, employers and state welfare funds, or under any other benefit or entitlement plan. I authorize the release of any medical information deemed necessary by DCG or its agents or divisions to my insurance carrier or any entitlement program provider in order to determine the benefits applicable to this date of service. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that I am financially responsible for all charges, whether or not they are covered by my insurance carrier or entitlement plan, including Medicare. I understand that I am responsible for paying any co-payment or deductible amounts at each clinic visit.

I acknowledge that I have received DCG's Notice of Privacy Practices and the Patient Bill of Rights and Responsibilities. The Notice of Privacy Practices for DCG is also available in the clinic reception area. I recognize the information gathered by DCG may need to be disclosed to a third party for purposes of administration, treatment, payment, and other healthcare operations. I consent to such release.

I confirm that I have read, or have had this form read to me, and all questions related to this form have been answered by DCG providers.

PATIENT NAME (PLEASE PRINT)	**PATIENT DATE OF BIRTH**
SIGNATURE	**TODAY'S DATE**
RELATIONSHIP TO PATIENT, IF CONSENT NOT SIGNED BY PATIENT	**TELEPHONE NUMBER**

Notice of Privacy Practices

Effective Date: [April 14, 2003]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Diabetes Care Group (DCG) is required by law to maintain and protect the privacy of your Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("HIPAA").

USE AND DISCLOSURES OF PHI –DCG is permitted to use or disclose your PHI for the following purposes and in most cases without your written permission. The following examples describe different ways that we use and disclose your PHI.

- **Treatment**. We may use your health information to provide and coordinate the treatment, medications and services you receive. DCG may disclose this information to your doctors, nurses, registered dietitians or other staff who take care of you.
- **Payment**. We may use your health information for various payment-related functions. We may contact your insurer, or other health care payer to determine whether it will pay for your treatment and the amount of your co-payment.
- **Health Care Operations**. We may use your health information for certain operational, administrative and quality assurance activities, including day-to-day business activities. Example: We may use information in your health record to monitor the performance of the staff providing treatment to you. This information will be used in an effort to continually improve the quality and effectiveness of the health care and service we provide. We may disclose health information to business associates if they need to receive this information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of health information.

USE AND DISCLOSURES OF PHI WITHOUT WRITTEN AUTHORIZATION – In addition to treatment, payment or health care operations discussed above, DCG is permitted to use or disclose your PHI *without* your written authorization in the following instances:

- **Food and Drug Administration (FDA) -** We may disclose to the FDA, or persons under the jurisdiction of the FDA, PHI relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.
- **Fraud Prevention** – We may disclose you PHI in order to detect health care fraud and abuse and maintain compliance with applicable laws and regulations.
- **Health Oversight Activities -** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings -** Disclosure may be necessary for law enforcement activities in limited situations (in response to a court or administrative order, or in response to a valid and appropriate subpoena or other legal process).
- **Law Enforcement -** We may disclose your PHI for law enforcement purposes in limited situations (including,but not limited to when there is a warrant for the information, or when the information is needed to locate a suspect or stop a crime).
- **Military and Veterans -** If you are a member of the armed forces, we may release PHI about you as required by military command authorities.
- **National Security -** We may release PHI about you to federal officials for intelligence, counterintelligence, protection to the President, and other national security activities authorized by law.
- **Research -** In limited situation, we may disclose your PHI for research projects.
- **Victims of Abuse or Neglect -** We may disclose PHI about you to a government authority if we reasonably believe that you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law and we believe it is necessary to prevent serious harm to you or someone else.
- **Worker's Compensation -** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Communication Barriers** – We may use or disclose your PHI if your health care provider or other DCG personnel tries to communicate with you for treatment purposes but is unable to do so due to a communication barrier and the provider or other personnel determines, using his/her professional judgment, that you intend to authorize the use or disclosure under the circumstances (e.g., language barriers where an interpreter is needed or hearing impairment is involved).

AUTHORIZATION

DCG will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

MARKETING & FUNDRAISING

DCG may only use and/or disclose your PHI for marketing activities if we obtain from you prior written authorization. "Marketing" activities include communications to you that encourage you to purchase or use a product or service, and the communication is not made for your care or treatment. Additionally, DCG must obtain from you prior written authorization for any disclosure that results in the sale of your PHI.

DCG may use and/or disclose your demographic information and the dates that you received treatment from DCG, as necessary, in order to contact you for fundraising activities supported by DCG. If you do not want to receive these materials, please contact DCG's Privacy Office at the address listed below to request, in writing, that these fundraising materials not be sent to your and/or to restrict the use of your PHI for these purposes.

PATIENT RIGHTS

1. As a patient of DCG, you have the right to: **Request a restriction on certain uses and disclosures of PHI** - You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the DCG Privacy Office. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business.
2. **Request a restriction of disclosure of PHI to Health Plan** - You have the right to request a restriction of disclosure of your PHI to your health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the PHI pertains solely to a health care item or service for which you, or another person other than the health plan, has paid DCG in full.
3. **Receive Confidential Communications**- You have the right to receive confidential communications or information by alternative means or at alternative locations. You must submit a written request to the DCG Privacy Office. We will accommodate all reasonable requests.
4. **Inspect and obtain a copy of PHI** - In most cases, you have the right to access and copy the PHI that we maintain about you. To inspect or copy your PHI, you must send a written request to the Privacy Office. We may charge you a fee for the costs of copying, mailing and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. You will have the right to have the denial reviewed as set forth more fully in the written denial notice.
5. **Request an amendment of PHI** - If you feel that PHI we maintain about you is incomplete or incorrect, you may request that we amend it. To request an amendment, you must send a written request to the Privacy Office listed below. You must include a reason that supports your request. In certain cases, we may deny your request for amendment. If you disagree with the denial, you will have the right to submit a written statement of disagreement to DCG.
6. **Receive an accounting of disclosures of PHI -** You have the right to receive an accounting of the disclosures we have made of your PHI for most purposes other than treatment, payment, or health care operations. The right to receive an accounting is subject to certain exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to the Privacy Office listing (1) the time period for the accounting which may not be longer than six (6) years and (2) the form you would like to receive the accounting (such as paper or electronic copy).
7. **Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request** – DCG will prominently post a copy of this Notice on our web site (www.diabetescaregrp.com). You have the right to obtain a paper copy of this notice from DCG upon request.

REVISIONS TO THIS NOTICE

You also have the right to obtain a paper copy of this Notice upon request. You may request a copy of our current Notice at any time. Even if you have agreed to receive the Notice electronically, you are still entitled to a paper copy. You may obtain a paper copy from any DCG Clinic or DCG Corporate Office. DCG reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. A revised Notice will be promptly posted in our clinics and the DCG Web Site.

Where to obtain forms for submitting written requests outlined above - You may obtain forms for submitting written requests from any DCG Clinic or by contacting the Corporate Privacy Manager at Diabetes Care Group Privacy Office, 1040 River Oaks Drive Suite 302, Flowood, MS 39232 or by telephone at [601-939-9923]. You can also visit www.DiabetesCareGrp.com to obtain these forms.

LEGAL RIGHTS AND COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with the DCG Privacy Office at the address or telephone number listed below or with the Secretary of the United States Department of Health and Human Services. You may visit the following website for information on filing a complaint with the United States Department of Health and Human Services: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html .

Diabetes Care Group Privacy Office
1040 River Oaks Drive
Suite 302
Flowood, MS 39232
[601-939-9923]

DIABETES CARE GROUP'S REQUIREMENTS

1. Is required by law to maintain the privacy of your PHI and to provide you with this Notice stating our privacy practices with respect to your PHI.
2. Is required to abide by the terms of this Notice currently in effect.
3. Is required to notify you, in the event you are an affected individual, following a breach of unsecured PHI.
4. Reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all of your PHI that we maintain.
5. Will not retaliate against you for making a complaint.
6. Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.

PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

- To be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy
- To a prompt and reasonable response to question and requests
- To know who is providing medical services and who is responsible for his or her care
- To know what patient support services are available, including whether an interpreter is available if he or she does not speak English
- To know what rules and regulations apply to his or her conduct
- To be given by the health care provider information concerning diagnosis, planned course of treatment, alternative treatments, risks and prognosis
- To refuse any treatment, except as otherwise provided by law
- To be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her own care
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment whether the health care provider or health care facility accepts the Medicare assignment rate
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained
- To impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment
- To treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- To know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research
- To express grievances regarding any violation of his or her rights through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency

PATIENT RESPONSIBILITIES

- To provide the clinic provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health
- To report to the clinic provider unexpected changes in his or her condition
- To report to the clinic provider whether he or she comprehends a contemplated course of action and what is expected of him or her
- To follow the treatment plan recommended by the clinic provider
- To keep appointments and when he or she is unable to do so for any reason, to notify the clinic provider
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the clinic provider's instructions
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible
- A patient is responsible for following the clinic rules and regulations affecting patient care and conduct

DEFINITIONS

Complaint: Any written or verbal concern shared by a patient or his/her authorized representative that can be resolved by any staff member present or someone who can arrive quickly at the location to resolve the issue.

Grievance: A formal or informal, written or verbal expression of dissatisfaction in the care, treatment, and services received by a patient, or his/her authorized representative.

- It should be related to patient service or care issues made to the clinic and not promptly resolved by the staff present.
- A grievance requires additional staff time to research, investigate and resolve the concern or issue.
- It also requires individual communication with the patient.

Medical Grievance: A Medical Grievance is a grievance or complaint specific to the provision or non-provision of medical care or services. An example might be a grievance concerning medications, the need for a diagnostic procedure, or a request for an opinion from another medical practitioner.

Laboratory Grievance: A Laboratory Grievance is a concern that you may have about a laboratory's operation. (Examples include but are not limited to; quality of testing, unlabeled specimens, laboratory personnel qualifications).

DIABETES Care Group

Form 600D

PATIENT INFORMATION SHEET

(PLEASE PRINT)

PATIENT INFORMATION

☐ MR. ☐ MRS. ☐ MS.	FIRST NAME	MIDDLE INITIAL	LAST NAME
STREET ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE	
☐ MARRIED ☐ SINGLE	IF MARRIED, SPOUSE'S NAME	SPOUSE'S DATE OF BIRTH	

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ AMERICAN INDIAN/ALASKA NATIVE	☐ HISPANIC	☐ ENGLISH
☐ ASIAN/ PACIFIC ISLANDER	☐ NON-HISPANIC	☐ SPANISH
☐ BLACK/AFRICAN AMERICAN	☐ UNKNOWN	☐ OTHER
☐ WHITE		
☐ OTHER		

PREFERRED PHONE NUMBER		CAN DIABETES CARE GROUP LEAVE A MESSAGE AT THESE NUMBERS? ☐ YES ☐ NO
ALTERNATE PHONE NUMBER		
E-MAIL ADDRESS	CAN DIABETES CARE GROUP SEND YOU ADDITIONAL INFORMATION TO THIS E-MAIL ADDRESS? ☐ YES ☐ NO	
WHO REFERRED YOU TO DIABETES CARE GROUP		
PRIMARY CARE PHYSICIAN (PCP) NAME	PRIMARY CARE PHYSICIAN PHONE NUMBER	

INSURANCE INFORMATION

(PRIMARY INSURANCE) INSURED RELATIONSHIP TO PATIENT ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **GUARDIAN**			
PRIMARY INSURANCE CARRIER	INSURANCE IDENTIFICATION NUMBER	GROUP NUMBER	CO-PAY AMOUNT ($)
INSURED FIRST NAME	INSURED LAST NAME	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY NUMBER
(SECONDARY INSURANCE) INSURED RELATIONSHIP TO PATIENT ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT** ☐ **GUARDIAN**			
INSURANCE CARRIER	INSURANCE IDENTIFICATION NUMBER	GROUP NUMBER	CO-PAY AMOUNT ($)
INSURED FIRST NAME	INSURED LAST NAME	INSURED DATE OF BIRTH	INSURED SOCIAL SECURITY NUMBER

INSURANCE CARD AND PHOTO IDENTIFICATION REQUIRED

EMERGENCY CONTACT INFORMATION

FIRST NAME	LAST NAME	PHONE NUMBER

SHARING OF MEDICAL INFORMATION

IS THERE A FAMILY MEMBER, FRIEND, OR OTHER PERSON INVOLVED IN YOUR CARE OR PAYMENT FOR CARE THAT DIABETES CARE GROUP CAN SHARE YOUR MEDICAL INFORMATION? ☐ YES ☐ NO

FIRST NAME	LAST NAME	RELATIONSHIP
FIRST NAME	LAST NAME	RELATIONSHIP

NEW PATIENT MEDICAL HISTORY

ANSWER THE FOLLOWING QUESTIONS WITH AS MUCH DETAIL AS POSSIBLE.
THIS INFORMATION WILL HELP US PROVIDE QUALITY CARE TO YOU.

PATIENT INFORMATION

NAME	PHONE NUMBER	
E-MAIL ADDRESS	☐ MALE ☐ FEMALE	AGE

1. WHAT ARE YOUR WORK HOURS

2. LAST GRADE COMPLETE IN SCHOOL

3. WHAT IS YOUR LANGUAGE PREFERENCE (SPOKEN) ☐ ENGLISH ☐ SPANISH ☐ OTHER _____
(WRITTEN) ☐ ENGLISH ☐ SPANISH ☐ OTHER _____

4. HOW DO YOU GET TO THE CLINIC ☐ DRIVE SELF ☐ FAMILY ☐ MEDICAID TRANSPORT ☐ BUS/TAXI ☐ FRIEND DRIVES ☐ PAY SOMEONE TO DRIVE YOU

5. PRIMARY CARE DOCTOR NAME	PHONE NUMBER	ADDRESS/LOCATION

6. WHAT OTHER DOCTORS DO YOU SEE — LIST THE PROBLEMS YOU SEE THE DOCTOR FOR

_____ _____
_____ _____
_____ _____

RECENT MEDICAL HISTORY

7. HAVE YOU BEEN IN THE HOSPITAL IN THE LAST SIX (6) MONTHS ☐ YES ☐ NO
IF YES, WHY

8. HAVE YOU BEEN IN THE EMERGENCY ROOM IN THE LAST SIX (6) MONTHS ☐ YES ☐ NO
IF YES, WHY

DIABETES HISTORY

9. WHAT TYPE OF DIABETES DO YOU HAVE ☐ TYPE 1 DIABETES ☐ GESTATIONAL DIABETES ☐ TYPE 2 DIABETES ☐ OTHER

10. WHAT YEAR WERE YOU DIAGNOSED WITH DIABETES

11. ARE YOU ON AN INSULIN PUMP ☐ YES ☐ NO

12. DO YOU, OR HAVE YOU HAD ANY OF THE FOLLOWING

☐ HIGH BLOOD PRESSURE
☐ CHOLESTEROL PROBLEMS
☐ CORONARY ARTERY OR HEART DISEASE
☐ HEART FAILURE
☐ STROKE
☐ BLOOD FLOW BLOCKAGE TO YOUR LEGS (PERIPHERAL VASCULAR DISEASE)
☐ NUMBNESS/PAIN IN FEET OR LEGS FROM DIABETES (NEUROPATHY)
☐ KIDNEY PROBLEMS
☐ DIABETIC EYE DISEASE (RETINOPATHY)
☐ SEXUAL DYSFUNCTION
☐ FOOT ULCERS
☐ AMPUTATION
☐ DIABETIC STOMACH PROBLEMS (GASTROPARESIS)

MEDICATIONS

13. WHAT IS YOUR PHARMACY'S NAME	WHAT IS YOUR PHARMACY'S PHONE NUMBER

14. LIST ALL MEDICATIONS AND SUPPLEMENTS THAT YOU ARE TAKING (REMEMBER, INSULIN IS A MEDICINE)

MEDICINE	DOSE	HOW OFTEN

15. DO YOU HAVE ALLERGIES TO MEDICINES OR FOODS ☐ YES ☐ NO (IF YES, PLEASE LIST BELOW)

MEDICINE	FOOD

MEDICAL HISTORY

16. PLEASE LIST ANY AND ALL HEALTH PROBLEMS YOU HAVE BESIDES DIABETES

17. PLEASE LIST ANY SURGERIES YOU HAVE EVER HAD

18. HAVE YOU EVER HAD A SHOT TO PREVENT PNEUMONIA ☐ YES ☐ NO IF YES, WHEN

19. HAVE YOU HAD A FLU SHOT WITHIN THE LAST YEAR ☐ YES ☐ NO

20. (**FOR WOMEN ONLY**) HAVE YOU EVER BEEN PREGNANT ☐ YES ☐ NO

IF YES, HOW MANY TIMES _____ HOW MANY LIVE BIRTHS _____

DID YOU GET DIABETES WHEN YOU WERE PREGNANT ☐ YES ☐ NO

WHEN WAS YOUR LAST PERIOD _____

ARE USING ANY BIRTH CONTROL ☐ YES ☐ NO WHAT METHOD _____

ARE YOU PREGNANT ☐ YES ☐ NO ARE YOU PLANNING ON BECOMING PREGNANT ☐ YES ☐ NO

SOCIAL HISTORY

21. WHAT IS YOUR OCCUPATION

22. MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ OTHER

23. HAVE YOU EVER SMOKED OR USED TOBACCO ☐ YES ☐ NO (IF YES, PLEASE DESCRIBE)

WHAT TYPE AND HOW MUCH	FOR HOW LONG	HAVE YOU MADE ANY EFFORTS TO QUIT

24. DO YOU DRINK ALCOHOL ☐ YES ☐ NO (IF YES, PLEASE DESCRIBE)

TYPE OF ALCOHOL _____ HOW MUCH _____

25. DO YOU OR HAVE YOU EVER USED DRUGS (MARIJUANA, COCAINE, HEROIN, ETC.) ☐ YES ☐ NO

FAMILY HISTORY

26. IS THERE ANY HISTORY OF THE FOLLOWING IN YOUR PARENTS, YOUR SIBLINGS, OR YOUR CHILDREN	PARENTS	SIBLINGS	CHILDREN
TYPE 1 DIABETES	☐	☐	☐
TYPE 2 DIABETES	☐	☐	☐
ANOTHER TYPE OF DIABETES	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
CHOLESTEROL PROBLEMS	☐	☐	☐
HEART DISEASE	☐	☐	☐
STROKE	☐	☐	☐
BLOOD FLOW BLOCKAGE IN THE LEGS (PERIPHERAL VASCULAR DISEASE)	☐	☐	☐
CANCER	☐	☐	☐
THYROID PROBLEMS	☐	☐	☐
LUPUS, RHEUMATOID ARTHRITIS, OR OTHER AUTOIMMUNE DISEASE	☐	☐	☐

27. IS YOUR FATHER LIVING ☐ YES ☐ NO HOW OLD IS/WAS HE _____

WHAT DISEASES DOES/DID HE HAVE _____

28. IS YOUR MOTHER LIVING ☐ YES ☐ NO HOW OLD IS/WAS SHE _____

WHAT DISEASES DOES/DID SHE HAVE _____

REVIEW OF SYSTEMS

29. ARE YOU CURRENTLY HAVING ANY OF THESE SYMPTOMS

YES	NO	CONSTITUTIONAL	YES	NO	EYES
☐	☐	FEVERS	☐	☐	CHANGE IN VISION
☐	☐	CHILLS	☐	☐	LOSS OF VISION
☐	☐	NIGHT SWEATS	☐	☐	DOUBLE VISION
☐	☐	FATIGUE	☐	☐	EYE PAIN
☐	☐	LOSS OF APPETITE	☐	☐	DO YOU WEAR GLASSES
☐	☐	WEIGHT LOSS	☐	☐	OTHER
☐	☐	EXCESSIVE SLEEPINESS IN THE DAYTIME			
☐	☐	EXCESSIVE SNORING			
☐	☐	OTHER			

YES	NO	HEENT	YES	NO	RESPIRATORY
☐	☐	LOSS OF HEARING	☐	☐	COUGH
☐	☐	RINGING IN YOUR EARS	☐	☐	PHLEGM OR SPUTUM
☐	☐	DIZZINESS/VERTIGO	☐	☐	WHEEZING
☐	☐	CHANGE IN YOUR VOICE	☐	☐	SHORTNESS OF BREATH
☐	☐	LUMP OR GROWTH ON YOUR NECK	☐	☐	COUGHING UP BLOOD
☐	☐	SINUS CONGESTION OR DRAINAGE	☐	☐	PAIN IN CHEST WITH DEEP BREATHING
☐	☐	SORE THROAT	☐	☐	OTHER
☐	☐	OTHER			

YES	NO	CARDIOVASCULAR	YES	NO	GASTROINTESTINAL
☐	☐	CHEST PAIN	☐	☐	SWALLOWING TROUBLE
☐	☐	SHORTNESS OF BREATH WITH EXERCISE/EXERTION	☐	☐	INDIGESTION
☐	☐	DO YOU HAVE TO SLEEP PROPPED UP ON EXTRA PILLOWS AT NIGHT	☐	☐	REFLUX
☐	☐	DO YOU WAKE UP SUDDENLY SHORT OF BREATH AT NIGHT	☐	☐	NAUSEA OR VOMITING
☐	☐	DO YOUR ANKLES SWELL	☐	☐	ABDOMINAL PAIN OR TENDERNESS
☐	☐	DO YOU BLACK OUT OR FAINT	☐	☐	CONSTIPATION
☐	☐	DOES YOUR HEART SKIP BEATS, BEAT FUNNY, OR GO TOO FAST OR TOO SLOW	☐	☐	BLOOD STOOL
☐	☐	DO YOUR CALVES ACHE WITH WALKING	☐	☐	BLACK STOOL
☐	☐	OTHER	☐	☐	DIARRHEA
			☐	☐	OTHER

YES	NO	GENITOURINARY	YES	NO	MUSCULOSKELETAL
☐	☐	PAIN WITH URINATION	☐	☐	MUSCLE PAIN
☐	☐	FREQUENCY OF URINATION	☐	☐	MUSCLE TENDERNESS
☐	☐	URGENCY TO URINATE	☐	☐	JOINT PAIN
☐	☐	BLOOD IN URINE	☐	☐	JOINT TENDERNESS
☐	☐	KIDNEY STONES	☐	☐	JOINT SWELLING
☐	☐	DECREASE URINARY STREAM	☐	☐	OTHER
☐	☐	DO YOU GET UP MORE THAN THREE TIME PER NIGHT TO URINATE			
☐	☐	URETHRAL DISCHARGE			
☐	☐	ERECTILE DYSFUNCTION			
☐	☐	OTHER			

REVIEW OF SYSTEMS (CONTINUED)

YES	NO	SKIN	YES	NO	NEUROLOGICAL
☐	☐	RASH	☐	☐	NUMBNESS OR TINGLING
☐	☐	ITCHING	☐	☐	HEADACHES
☐	☐	SORES	☐	☐	MIGRAINES
☐	☐	LUMPS	☐	☐	WEAKNESS
☐	☐	MOLES THAT ARE CHANGING APPEARANCE	☐	☐	PARALYSIS
☐	☐	LUMP IN YOUR BREAST	☐	☐	TREMOR OR SHAKES
☐	☐	TENDERNESS IN YOUR BREAST	☐	☐	WALKING PROBLEMS
☐	☐	DISCHARGE FROM YOUR BREAST	☐	☐	SPEECH PROBLEMS
☐	☐	OTHER	☐	☐	LOSS OF MEMORY
			☐	☐	OTHER

YES	NO	PSYCHIATRIC	YES	NO	ENDOCRINE
☐	☐	DEPRESSION	☐	☐	LARGE VOLUMES OF URINE
☐	☐	ANXIETY	☐	☐	DRINKING LARGE VOLUMES OF WATER
☐	☐	INSOMNIA	☐	☐	NEEDING TO EAT ALL THE TIME
☐	☐	HALLUCINATIONS	☐	☐	BLURRY VISION
☐	☐	OTHER	☐	☐	WEIGHT GAIN
			☐	☐	EXCESSIVELY HOT ALL THE TIME
			☐	☐	EXCESSIVELY COLD ALL THE TIME
			☐	☐	ABNORMAL OR IRREGULAR PERIODS
			☐	☐	LOSS OF INTEREST IN SEXUAL ACTIVITY
			☐	☐	SWOLLEN GLANDS/LYMPH NODES
			☐	☐	OTHER

YES	NO	HEMATOLOGICAL	YES	NO	IMMUNOLOGICAL/ALLERGIC
☐	☐	EASY BRUISING	☐	☐	SEASONAL ALLERGIES
☐	☐	EASY BLEEDING	☐	☐	HIVES
☐	☐	BLOOD CLOTS	☐	☐	ASTHMA
☐	☐	LOW BLOOD COUNTS	☐	☐	FOOD ALLERGIES
☐	☐	OTHER	☐	☐	OTHER

DIABETES EDUCATION

30. HAVE YOU HAD ANY FORMAL DIABETES EDUCATION ☐ YES ☐ NO

IF YES, WHEN AND WHERE _____

31. HOW DO YOU BEST LIKE TO LEARN NEW INFORMATION ☐ HEARING ☐ WATCHING ☐ READING ☐ GROUPS

32. PLEASE GRADE YOURSELF ON	HOW WELL YOU KNOW						HOW WELL DO YOU DO				
HEALTHY EATING	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**
BEING ACTIVE	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**
MONITORING	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**
TAKING MEDICINE	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**
PROBLEM SOLVING	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**
COPING	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**
REDUCING RISKS OF COMPLICATIONS	**A**	**B**	**C**	**D**	**F**		**A**	**B**	**C**	**D**	**F**