



Atlanta Diabetes Associates
(404) 355-4393

77 Collier Rd, Suite 2080
Atlanta, GA, 30309

DIABETES AND ENDOCRINOLOGY PATIENT QUESTIONNAIRE

BRUCE W. BODE, M.D.
PAUL C. DAVIDSON, M.D.
DAVID G. ROBERTSON, M.D.
N. SPENCER WELCH, M.D.
C. ELISA LEBLANC, M.D.
JOE JOHNSON, PA-C
STACI KIES, PA-C
PAT RICHARDSON, N.P.

NAME _____
ADDRESS _____

PRIMARY M.D. _____
REFERRING M.D. _____
M.D. ADDRESS _____

INSTRUCTIONS:

Please answer all questions to the best of your ability. Answer all questions with either yes or no, but leave them blank if you are not sure.

GENERAL HEALTH (circle) Excellent Good Fair Poor

CHIEF COMPLAINT:

Please state briefly the main problem which prompted you to come and the length of time you have had it.

PHYSICAL NOTES:

PAST MEDICAL HISTORY

(Illnesses you have been diagnosed with.)

ILLNESSES	YES	NO	YEAR
AIDS			
BLOOD DISORDERS			
BROKEN BONES			
CANCER			
DIABETES			
EMOTIONAL DISORDER			
GI DISORDERS			
HEART DISEASE			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LIVER DISEASE			
NEUROLOGICAL DISORDER			
OTHER MAJOR ILLNESSES			
PERIPHERAL VASCULAR DISEASE			
SKIN DISEASE			
THYROID PROBLEMS			
TUBERCULOSIS			

LIST ALL SURGERIES

YEAR

IMMUNIZATIONS

	YES	NO	YEAR
FLU			
HEPATITIS B			
PNEUMOVAX			
TETANUS			

SOCIAL HISTORY:

OCCUPATION _____ HOURS PER WEEK _____

MARITAL STATUS _____ HEALTH OF SPOUSE _____

HIGHEST LEVEL OF EDUCATION _____

DO YOU GET REGULAR EXERCISE? _____

WHAT TYPE? HOW OFTEN? _____

DO YOU EAT A HEALTHY DIET? _____

HOW OFTEN DO YOU EAT THE FOLLOWING?

CHEESE	
FAST FOODS	
FRIED FOODS	
MILK	
YOGURT	

FAMILY HISTORY:

FAMILY	ALIVE (Health)	AGE	DECEASED (Cause)	AGE
FATHER				
MOTHER				
BROTHER				
SISTER				
SON				
DAUGHTER				

PHYSICAL NOTES:

HAVE ANY RELATIVES HAD THE FOLLOWING ILLNESSES?

ILLNESSES	YES	NO	IF YES, WHAT RELATION?
CANCER			
CIRCULATION PROBLEMS			
DIABETES			
GOITER OR THYROID PROBLEM			
HEART DISEASE			
HIGH BLOOD PRESSURE			
HIP FRACTURES			
KIDNEY DISEASE			
STROKES			
TUBERCULOSIS			
OTHER			

PHYSICAL NOTES:

REVIEW OF SYSTEMS:

PLEASE CHECK YES OR NO REGARDING THE FOLLOWING SYMPTOMS, IF YOU ARE NOT SURE LEAVE IT BLANK.

GENERAL

	YES	NO
CHANGE OF APPETITE		
CHANGE IN WEIGHT		
CHILLS		
DIFFICULTY SLEEPING		
FEVER		
NIGHT SWEATS		
TIREDDNESS		
WEAKNESS		
WEIGHT AT AGE 20		

PHYSICIAN NOTES

EYES, EARS, NOSE & THROAT**PHYSICIAN NOTES**

	YES	NO
DIFFICULTY WITH EARS OR HEARING		
DIFFICULTY WITH EYES OR VISION		
DIFFICULTY WITH YOUR NOSE		
DIFFICULTY WITH TEETH OR GUMS		
HAY FEVER		
INFECTION OF THE EYES		
PAIN IN EYES		
SINUS TROUBLE		
SPOTS BEFORE YOUR EYES		

RESPIRATORY**PHYSICIAN NOTES**

	YES	NO
COUGH		
SHORTNESS OF BREATH		
SPUTUM		
WHEEZING		

CARDIOVASCULAR**PHYSICIAN NOTES**

	YES	NO
CHEST PAIN		
HEART MURMUR		
HEART RACING OR PALPITATIONS		
LEG PAIN OR CRAMPING WHILE WALKING		
LEG PAIN AT REST		
SWELLING OF THE LEGS		

ENDOCRINE**PHYSICIAN NOTES**

	YES	NO
DO YOU PREFER HOT OR COLD TEMPERATURES		
CHANGE IN PITCH OF VOICE		
GOITER		
INCREASED OR DECREASED BODY HAIR		

NEUROLOGICAL/PSYCHIATRIC**PHYSICIAN NOTES**

	YES	NO
DEPRESSION		
HEADACHES		
LOSS OF CONSCIOUSNESS		
LOSS OF SENSATION		
SEIZURE		
WEAKNESS OF LIMBS		

GASTROINTESTINAL**PHYSICIAN NOTES**

	YES	NO
ABDOMINAL PAIN		
BLACK STOOLS		
BLOOD IN STOOLS		
CHANGE IN BOWEL HABITS		
CONSTIPATION		
DIARRHEA		
HEARTBURN		
NAUSEA		
VOMITING		

MUSCULOSKELETAL**PHYSICIAN NOTES**

	YES	NO
DEFORMITIES OF THE JOINTS OR EXTREMITIES		
PROBLEMS WITH MUSCLES OR JOINTS		

SKIN**PHYSICIAN NOTES**

	YES	NO
DRY OR OILY SKIN		
RASH		
SKIN CANCER		

URINARY SYSTEM**PHYSICIAN NOTES**

	YES	NO
AN UNUSUALLY LARGE VOLUME OF URINE		
DIFFICULTY STARTING OR STOPPING FLOW		
FREQUENT URINATION		
GETTING UP AT NIGHT TO URINATE		
PAIN OR BURNING WHILE URINATING		

GENITO-REPRODUCTIVE(MALE)**PHYSICIAN NOTES**

	YES	NO
DISCHARGE FROM PENIS		
DECREASED ABILITY TO ACHIEVE AND ERECTION		
DECREASED SEXUAL DESIRE		
HISTORY OF VENEREAL DISEASE		
LUMPS IN TESTICLES OR SCROTUM		

BREASTS**PHYSICIAN NOTES**

	YES	NO
LAST MAMMOGRAM		
LUMPS/DISCHARGE		

