Diabetes Education and Wellness
1910 Route 35 S, Oakhurst, NJ 07755
Phone: 732-676-8381 Fax: 732-876-3059

Last Name:_____**First Name:** _____**DOB:**_____**Sex**_____**Gender Identity**____
Marital Status_____ **Phone: Cell:** _____ _____**Home**_____
Insurance:_____**Subscriber Name**_____
Occupation:_____**Employer:**_____
Address: _____ _____

Medications- Please include ALL medications you take regularly (ALL vitamins, supplements or herbals)
Pharmacy Name: _____ **Phone**_____

Name of Medication	Dose	How Often	Year Started (approx.. is ok)

Do you have **allergies to medications**? Yes / No
If yes, please list: _____
Do you have **an allergy to Latex**? Yes / No **Surgical tape?** Yes / No
Do you have **allergies to food**? Yes / No If yes, please list: _____

Prior Surgeries:	**Yes**	**No**
Previous coronary angioplasty or stents	**Yes Date:**	**No**
Previous heart surgery	**Yes Date:**	**No**
Please list other surgeries and dates		
Previous Bariatric Surgery: Yes No Type of Surgery: _____ Date: _____ Where: _____ Surgeon: _____		
Weight at the time of surgery: lbs.	Reason for coming to this center:	
Notes:		

Medical History

Smoking History: Never Current Quit **Type:** Smoke___(cigarettes etc) Smokeless___(electronic cigarette))
Year quit:_____ **How long did you smoke**:_____years **How many times per day**:_____
Constant exposure to smoke (ei :spouse,partner,parents smoked)? Yes No

Alcohol	No:	Yes	How many_____per_____
Diabetes	Yes	No	Year Dx:
High Blood Pressure	Yes	No	Year Dx:
GERD	Yes	No	Latest Endoscopy date:
High Cholesterol	Yes	No	Year Dx:
Heart Disease	Yes	No	Year Dx:
Asthma	Yes	No	
Arthritis	Yes	No	

 Reviewed by:_____Date_____

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Back Pain	Yes	No	
Leg Ulcers Leg discoloration	Yes	No	
Cancer	Yes	No	Year Dx: Type:
Depression	Yes	No	
COPD	Yes	No	Year Dx:
PE(blood clot in lungs)	Yes	No	Year Dx:
DVT(blood clot in legs)	Yes	No	Year Dx:
TIA (Mini Stroke)	Yes	No	When?
Stroke	Yes	No	When?
Gallstones/Gallbladder Disorder	Yes	No	Surgery: Yes /No Date
Polycystic Ovarian Syndrome	Yes	No	
Bleeding Disorder	Yes	No	
Liver Disorder	Yes	No	
Kidney Disorder	Yes	No	Year Dx: Dialysis? Yes No
Thyroid Disorder	Yes	No	
Seizure Disorder	Yes	No	
Migraines	Yes	No	Med:

Ambulation:	Independent:	Assisted: Type of assistive device:	
Activities of daily living	Independent	Dependent Partial	Dependent Total
Number of hours of sleep per night:_____ Quality: *Interrupted__ Restful___* ***Wakes up:*** *Rested___Tired____*			
Requiring oxygen:	Yes	No	
Sleep study done:	Yes	No	
Obstructive Sleep Apnea	Yes	No	
CPAP/BiPAP required:	Yes	No	

Any Other Medical History- Please list **ALL** other medical history

Test/Procedure	**Date**	**Performed by/Where**
Colonoscopy		
Mammogram		
DEXA (osteoporosis) scan		
Carotid Ultrasound		
PSA + DRE		
Stress test		
ECG		
Bloodwork		
Eye Exam		
Podiatry		
Vaccine: Flu		
Pneumonia		
Tetanus		
Other:_____		
PCP:		**Tel. #:**

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FAMILY HISTORY – Please mark "**x**" to all that apply

Family Member	Obesity	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Cancer (type)	Bleeding Disorder (Type)	Anxiety & Depression	Others
Father									
Mother									
Siblings									
Children									

Activity {if not marked, it will be assessed as Inactive}

Home: Inactive___ Moderately Inactive ____Active____ Moderately Active _____
Work: Inactive___ Moderately Inactive ____Active____ Moderately Active _____
Exercise: _____per week; _____min/hours per session
Other description:_____

_____

Weight Loss History

Current Weight:_____ lbs. How long have you been at your present weight? _____ yrs.
What is the highest weight in the last 10 years? _____ lbs. What is the lowest weight in 5 years? _____lbs.
Physical symptoms due to weight gain:_____
Psychosocial symptoms due to weight gain:_____
Any previous use of medically supervised weight management? Yes / No
Provider or Clinic City: Treatment Dates: Type of Treatment: _____
Have you tried diet pills? Yes / No If yes, please list: _____ How long? _____
What do you think contributed to weight gain?_____
What is your primary reason for wanting to lose weight?_____
Are you willing to adapt to recommended dietary and activity changes?_____
What do you think is the most challenging part of weight management?_____

_____

Please check all that you have tried **IN THE LAST 10 YEARS. (if not listed please write-in)**

	Year	Weight Loss (lbs.)			Year	Weight Loss (lbs.)
Atkins				Medifast		
Acupuncture				Nutrisystem		
Calorie Counting				Nutritionist		
Diet Center				Optifast		
Fad Diet				Overeaters Anonymous		
HCG						
Herbal Diet				Pritikin		
Health Spa				Self-Diet		
High Protein				Slim Fast		
Hypnosis				South Beach		
Jenny Craig				Weight Watchers		
LA Diet				Zone		
Low Carbohydrate				Other:		

Do you have a living will (advance directive)? Yes No If no, do you want information? Yes No
Emergency Contact:_____ Relationship:_____
Phone:_____
Signature: _____ Date:_____

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Eating Questionnaire

Name:_____ Date: _____

1. Have you received nutrition counseling in the past: YES No
   If yes where_____
2. Do you follow a special diet? YES NO
   Diabetic____ Low Sodium____ Low Fat____ Vegetarian____ High protein ____Raw ____Other:_____
3. What meal do you eat regularly?
   Breakfast_____Lunch_____Brunch_____Dinner_____
4. How often do you snack?
   Mid-Morning: _____Mid PM: _____Evening _____Late night _____Throughout the day_____
   What is your favorite snack? _____
5. How often do you eat out or order out? Daily_____ Weekly _____Monthly _____Other_____
   What kind of foods?_____

6. How many times per day do you eat the following :	Never	Less than 1	1-2	3-5	6-8	9-11	Other
Starch(Beans, Rice, Pasta,Breads)							
Fruits							
Vegetables							
Dairy (milk, yogurt)							
Meat, Fish,							
Fat(butter, mayonnaise, oils, salad dressings)							
Nuts							
Cheese							
Sweets(candy, cakes)							

7. Please write down the amounts of each beverage drink and how much per day?
   Water:_____ Juice:_____ Alcohol_____
   Coffee:_____ Regular Soda_____ Other:_____
   Tea:_____ Diet Soda_____
8. Do you use any meal replacements? YES NO
   If yes what and how often:_____
9. Which eating habits do you like to change? _____
10. Is there anything in particular you want to add?_____
    _____