My Diabetes Dietitian, Inc.

Please bring completed form to first appointment

Today's Date: ______________

Personal Information:

Name____

Last First Middle

Mailing Address ____

City______________________State_____________Zip Code_______

Date of Birth________

Home Telephone____________________ Cell phone_______________________

Email address____

Marital Status: ______________________________

Insurance carrier: __________________________

Subscriber number: _______________________

Relationship to subscriber: Self or spouse or child

Who referred you? _____________________________________

What can I help you with? Goals desired?

____

____

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____

Have you seen Dietitian before and what was your experience?

____

Do you prefer structured plan or more loose guidelines?

____

Medical Information:

Name of Physician: ______________________City_________________

Physician phone number: __________________________

Height ____________ Current Weight __________ Desired Weight _________

Lowest adult weight____________ Highest adult weight_____________

Please list all medications including prescription/vitamins/herbs

____

____

Please list any chronic medical issues you may have such as diabetes, high blood pressure, depression, high cholesterol, celiac, etc.

____

____

Most Recent Lab Values if known:

Blood Sugar_______________
HBA1C _______________
Blood Pressure____________
Total cholesterol ______ HDL ______ LDL______Tryglicerides________

(complete section below If diagnosed with pre diabetes or diabetes):
Have you every had diabetes education? _____
If so, where? ________________________

What type of diabetes do you have? Pre diabetes or Type 1 or Type 2

When diagnosed? _______________

Are you testing your blood sugar? ________ What times of day?________

What are your average readings?_________

What meter are you using? _________________________
Do you get any lows? < 70 mg/dl _______If so, do you treat the low sugars? _____________