Renown CHILDREN'S HOSPITAL
Renown Children's Hospital • 1155 Mill St. • Reno, NV 89502
775-982-KIDS (5437) • BestMedicineNews.org/kids • renown.org/children

Pediatric Endocrinology Established Diabetes Patient Health History

Name: _____ **DOB:** _____

List two (2) main concerns for today's visit:

1. _____
2. _____

Date of last eye exam:	**Circle one:** Was your eye exam NORMAL or ABNORMAL
Insulin: **<u>Circle one:</u>** Pens or Vials	**For injections only (skip if on insulin pump)** **Mealtime insulin:** ___ units for every ___ grams of carbohydrates **Correction dose:** ___ units for every ___ points BS is above ___
<u>Circle one:</u> Lantus, Levemir, Basaglar, Toujeo, Tresiba	**For injections only (skip if on insulin pump)** ___ units at ___ AM/PM

What glucose meter do you use? _____

Please circle if you need refill soon of any of the following medications:

- Glucagon
- Zofran (anti-nausea pill)
- Blood ketones strips
- Urine ketones strips
- Ketone meter
- Insulin syringes to administer mimi glucagon
- Back-up long acting insulin (*if on insulin pump only*)
- Other: _____

Other questions:

1. How often do you give insulin before a meal or snack? _____ % of the time.
2. Are you giving correction doses outside of mealtimes? YES or NO
3. How often in the last month have you woken to treat a low or blood sugar? _____
4. Where are you giving injections? ABDOMEN, HIPS, BUTTOCKS, ARMS, THIGHS, OTHER
5. Have you had any lab work or imaging performed recently that would impact this visit?
    a. YES or NO
        i. If yes – where were they performed: _____

Female only: Date of last menstrual period:_____

Please circle any symptoms the patient is experiencing:

Fatigue
Constipation
Vitiligo (loss of skin color)
Hyperpigmentation
Easy bruising
Excelssively dry skin
Hair loss
Rash
Itchy skin
Itchy eyes
Red eyes
Runny nose
Congestion
Fever
Ear pain
Sore throat
Swelling
Insomnia/sleep disturbance
Night sweats
Diarrhea

Loss of appetite
Amenorrhea (late/no periods, spotting)
Heartburn
Nausea
Vomiting
Weight loss
Weight gain
Increased hunger
Increased thurst
Increased urination
Urination at night
Painful urination
Blood in stool
Sensitivity to tempearatures (hot/cold)
Blurry vision
Decreased vision
Chest pain
Easy bruising

Palpitation
Shortness of breath
Coughing wheezing
Abdominal pain
Headaches/migranes
Numbness
Tingling
Tremors
Dizziness
Back pain
Joint pain
Joint swelling
Muscle cramping
Memory loss
Acne
Hives
Depression
Anxiety
High stress

Generalized Anxiety Disorder (GAD) Screening

Please circle only one answer for each question.

KEY: Not at all – 0, several days = 1, More than half the days = 2, Nearly everyday = 3

I am…

• Feeling nervous, anxious, or on edge	0	1	2	3
• Not able to stop or control worrying	0	1	2	3
• Worrying too much about different things	0	1	2	3
• So restless that it is hard to sit still	0	1	2	3
• Easily annoyed or irritable	0	1	2	3
• Feeling afraid as if something awful might happen	0	1	2	3

TOTAL Score: (5 = mild; 10 = moderate; 15 = severe)