UNIVERSITY DIABETES ENDOCRINE CONSULTANTS

Your Appointment
Date: / /
Time: :

Please email these forms to
awallin@drhuffman.com
no later than: / /

Patient Information

Date: / / Date of Birth: / / SS#: - -

Name: (last name) (middle initial) (first name)

Address: (street address) (city) (state) (zip code)

Primary Phone #: - - ☐ Home ☐ Cell Secondary Phone #: - -

Race: Ethnicity: Marital Status: Language:

Email Address:

Employer

Employer Name:

Employer Address: (street address) (city) (state) (zip code)

Employer Phone #: - -

Insurance

	Primary	Secondary
Company Name:		
Member ID:		
Group #:		
Responsible Party		
Name:		
Date of Birth:		
SS#:		

Emergency Contact

Name: Relationship:

Address: (street address) (city) (state) (zip code)

Phone #: - -

Circle of Care

	Physician Name	Phone #
Primary Care:		- -
Ophthalmologist:		- -
Nephrologist:		- -
Cardiologist:		- -
Podiatrist:		- -
Pulmonologist:		- -
Urologist:		- -

Medical / Family History Form

Which of your Physician's referred you to Dr. Huffman?

Physician Name

Why are you seeing Dr. Huffman?

Diabetes

Do you have diabetes? ☐ YES ☐ NO* *** please skip this section if no**

When were you diagnosed with diabetes? ___ / ___ / ___

Have you attended diabetes education? ☐ YES ☐ NO Dates:

Have you seen a dietitian or been given a diet? ☐ YES ☐ NO Kcal:

If you take insulin, do you use an insulin pump? ☐ YES ☐ NO An insulin pen? ☐ YES ☐ NO

Do you wear a continuous glucose monitor? ☐ YES ☐ NO

Please list any pills you take to control your diabetes

Drug Name	mg	Times Daily	B	L	S	HS
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

Medications

Preferred Pharmacy:

Address: (street address) (city) (state) (zip code)

Current Medications

Drug Name	Prescribing Physician	Breakfast	Lunch	Supper	Bedtime
		mg	mg	mg	mg
		mg	mg	mg	mg
		mg	mg	mg	mg
		mg	mg	mg	mg
		mg	mg	mg	mg
		mg	mg	mg	mg
		mg	mg	mg	mg
		mg	mg	mg	mg

Insulins

Medical / Family History Form

Allergies

Please list any allergies you have to medications

Medication	Reaction

Currently Receiving Treatment For

Medical Diagnosis	Treating Physician	Since Date
		/ /
		/ /
		/ /
		/ /

Hospitalization or Surgery

Hospitalization or Surgery	Date
	/ /
	/ /
	/ /
	/ /
	/ /

Family History

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Sister	Child	Grandchild
Diabetes Mellitus:										
Hypertension:										
Thyroid Problems:										
Cancer:										
Heart Attack:										
Stroke:										
High Cholesterol:										
Kidney Failure:										
Other										

Please mark each box below for family members who've had any of the following diagnoses

Type of Cancer:

Medical / Family History Form

*Additional fields if needed

Medications

Current Medications

Drug Name	Prescribing Physician	Breakfast		Lunch		Supper		Bedtime	
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg
			mg		mg		mg		mg

Insulins

Medical / Family History Form

*Additional fields if needed

Allergies

Please list any allergies you have to medications

Medication	Reaction

Currently Receiving Treatment For

Medical Diagnosis	Treating Physician	Since Date
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /
		/ /

Hospitalization or Surgery

Hospitalization or Surgery	Date
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /
	/ /