Patient Information Sheet

Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone #: _____ ☐ Cell ☐ Home

Email address: _____

Emergency contact: _____Phone #: _____

Primary care doctor: _____ Phone #: _____

May we contact your primary care doctor regarding your trial participation? ☐ Yes ☐ No

Consent for treatment

I grant permission for The Diabetes and Thyroid Center of Fort Worth to review any of my medical records, perform any tests, administer medications or perform any diagnostic testing as deemed necessary relating to specific trial protocol that I will be enrolled for.

Subject signature: _____ Date: _____

DIABETES AND THYROID CENTER OF FORT WORTH

Name: _____ Date of Birth: _____

PERSONAL MEDICAL HISTORY

Have you been diagnosed with Diabetes? ☐ Yes ☐ No

Type of Diabetes: _____ (Type 1 or Type 2)

Date of Diagnosis: _____

Have you had any surgeries? ☐ Yes ☐ No

Surgery	Year

List medications you have taken in the last year **(if stopped, please include stop date)**

Include diabetic medications

Medication	Dose & frequency	Date started/stopped	Reason for taking

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list the medication and reaction below

Medication	Reaction

Review of Systems

EARS, NOSE &THROAT	Yes	No	Start Date	Medication for Condition
Frequent ear infections				
Allergies(chronic or seasonal)				
Other:				
RESPIRATORY	**Yes**	**No**	**Start Date**	**Medication for Condition**
Asthma(past or present)				
Tuberculosis(past or present)				
Pneumonia(past or present)				
Chronic cough				
Shortness of breath				
Emphysema				
Other:				
CARDIOVASCULAR	**Yes**	**No**	**Start Date**	**Medication for Condition**
Heart murmur				
High blood pressure				
Chest pain(past or present)				
Chest tightness(past or present)				
Heart attack				
Abnormal EKG(past or present)				
Irregular heart rate(past or present)				
Rapid heart rate(past or present)				
High cholesterol				
High triglycerides				
Swollen ankles				
Aneurysm				
Stroke(MI, CABG, TIA)				
Coronary Artery Disease				
Peripheral Arterial Disease				
Heart failure(specify class)				
Other:				

GASTROINTESTINAL	Yes	No	Start Date	Medication for Condition
Frequent heart burn				
Frequent indigestion				
Gastroesophageal Reflux Disease(GERD)				
Frequent constipation				
Frequent diarrhea				
Frequent vomiting				
Gallbladder disease(current or past)				
Gallstones(current or past)				
Ulcers(where; current or past)				
Hepititas(A,B and/ or C)				
Digestive disease				
Other:				
GENITOURINARY	**Yes**	**No**	**Start Date**	**Medication for Condition**
Pain when voiding				
Frequent urination(past or present)				
Slowing of the urinary system				
Sense of incomplete voiding				
Blood in urine				
Kidney stones(past or present)				
Sexually transmitted disease(past or present)				
Diabetic nephropathy				
Other:				
PSYCHIATRIC	**Yes**	**No**	**Start Date**	**Medication for Condition**
General depression(past or present)				
Severe Depression(past or present)				
Anxiety				
Bipolar				
Other:				
ENDOCRINE/HORMONE	**Yes**	**No**	**Start Date**	**Medication for Condition**
Low testosterone				
Hypothyroidism				
Graves' Disease				
Thyroid nodules(benign/malignant; past or present)				
Pancreatitis				
Other:				

MUSCULAR-SKELETAL	Yes	No	Start Date	Medication for Condition
Arthritis (indicate where)				
Bursitis (indicate where)				
Tendonitis				
Tennis Elbow				
Disk Disease				
Gout				
Back/Neck pain (indicate which)				
Leg cramps				
Amputation (indicate where)				
Other:				
NEUROLOGICAL	**Yes**	**No**	**Start Date**	**Medication for Condition**
Frequent headaches				
Migraine headaches				
Blurred vision (past or present)				
Loss of vision (past or present)				
Loss of speech (past or present)				
Diabetic neuropathy				
Seizers (past or present)				
Other:				
SKIN	**Yes**	**No**	**Start Date**	**Medication for Condition**
Psoriasis (past or present)				
Eczema (past or present)				
Athlete's foots (past or present)				
Wound or ulcer(past or present)				
Other:				
IMMUNE SYSTEM	**Yes**	**No**	**Start Date**	**Medication for Condition**
Positive AIDS test				
HIV carrier				
Other:				
EYES	**Yes**	**No**	**Start Date**	**Medication for Condition**
Glaucoma				
Cataracts				
Diabetic retinopathy (stable or unstable)				
Last Eye Exam				
Other:				

HEMATOLOGIC	Yes	No	Start Date	Medication for Condition
Anemia				
Vitamin D deficiency				
Vitamin C deficiency				
Other:				
CANCER (Note if benign or malignant; past or present)	**Yes**	**No**	**Start Date**	**Medication for Condition**
GYNECOLOGIACAL (N/A for males)	**Yes**	**No**	**Start Date**	**Medication for Condition**
Previous pregnancy/pregnancies				
Currently pregnant				
Currently in menopause				
Post-menopausal				
Tubal ligation				
Partial hysterectomy				
Total hysterectomy				
Are you of child bearing potential?				
If yes, method of birth control				
Other:				

Have you had a hypoglycemic event (blood glucose level at or below 70) with in the last 12 months?

Yes ☐ No ☐

Have you had a hypoglycemic event that resulted in hospitalization, seizures, or coma in the last 12 months?

Yes ☐ No ☐

If yes to either above question, please list below:

Event Date	Symptoms	Outcome

EXERCISE

Do you exercise at all?
How often?
What type of exercise?
SMOKING HISTORY
Do you presently smoke?
Have you ever smoked?
If you smoke, or ever had smoked on average how many cigarettes do/did you smoke per day?
If you smoke have you ever tried to stop?
Dates smoked:
ALCOHOL USE
Do you drink alcohol? Yes ☐ No ☐
If yes, on average, how often do you drink alcohol?
☐ Never
☐ Monthly
☐ Weekly
☐ Daily
If yes, on average, how many drinks do you have at one time?
(1 drink= 1 shot of spirits, 1 glass of wine, 1 beer)
☐ 1
☐ 2-3
☐ 4 or more
MISCELLANEOUS
Have you ever used a continuous glucose monitor? Yes ☐ No ☐
Have you been in a clinical trial in the last 30 days? Yes ☐ No ☐
If so, have you taken/are you taking any trial medication drug in the last 30 days? Yes ☐ No ☐
When was your last dilated eye exam? _____/_____/_____
Are you a night shift worker? Yes ☐ No ☐

Date completed by subject: _____/_____/_____

Signature of subject: _____

Reviewed by: _____ Date: _____

PI review: _____ Date: _____

Authorization to Release Healthcare Information

Patient's name: _____
Last **First** **Middle initial**
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Primary phone number: _____

I hereby authorize and request: _____
to release healthcare information of the patient named above to:

The Diabetes and Thyroid Center of Fort Worth, PLLC
7801 Oakmont Blvd. Ste. 101
Fort Worth, TX 76132
Research Group
Phone # (817)644-3815
Fax # (817)263-1115

Records to include:
☐ All progress notes
☐ Lab results
☐ Radiology
☐ Hospital records
☐ Admission and discharge reports

I hereby authorize the Diabetes and Thyroid Center of Fort Worth to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand the if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will not expire until the end of participation in the research protocol. I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization.

Subject signature: _____ Date: _____