MOUNT NITTANY.
PHYSICIAN GROUP

1850 East Park Avenue, State College, PA 16803 814-234-8800; fax 814-689-1688

Dear Patient:

Thank you for expressing an interest in our diabetes treatment and education program. Since diabetes will stay with you the rest of your life, it is important that you learn as much as possible so you can make your own decisions about diabetes, both day-to-day and for the long term. It is important that your particular treatment suits your lifestyle as much as possible.

For these reasons, we ask you to set aside 2 hours for your first visit so that we may fully evaluate your case. At this visit you will meet with several members of the Diabetes team starting with one of our Nurse Practitioners and possibly a dietitian and/or a diabetes nurse educator. We will find out how much you know about diabetes and how you treat your diabetes. You may receive a physical examination and we may order blood tests. We will ask you about your views about diabetes and any changes you would like to make; then together we will decide how to proceed. Feel free to bring a family member or a friend if you would find this helpful.

Before coming to our office eat your usual meals and take your usual insulin and / or medications. This applies to all your subsequent visits as well – you never need to fast for any visits or blood tests that we ask for.

What to bring to your first visit:

- all medications, vitamins, and supplements you are taking (not just for diabetes)
- your glucose testing equipment
- **if you know how to test your blood sugar, bring results for 3 – 7 days; test at least 4 times per day - before breakfast, lunch, supper and bedtime snack, and any other time that you feel you need to; a log for keeping track of your blood sugar is attached**
- the three forms attached and completed - health history, "HAD Scale" and "Problem Areas in Diabetes"

Your first follow up visit will typically be 1 week later and will last an hour but visits thereafter will usually be shorter. At every visit we will strive to teach you a little more about how to live well with diabetes. Each of your visits with us will be with one or more of the members of the Diabetes Team who specialize in several different aspects of diabetes. Who you see will depend on what you and we think you need. You will not always see the doctor, but you can ask to have your next appointment with the doctor at any time.

What to bring to subsequent visits:

- **all your testing equipment**
- **your results log book**
- any new medications from another doctor

Date: _____

At Mount Nittany Physician Group (MNPG) we use the team approach to diabetes treatment. This approach is employed at most specialized diabetes clinics. The diabetes team is comprised of the patient, the MNPG Diabetes Team (endocrinologist, diabetes nurse educators, dietitians, and nurse practitioners) and importantly the patient's own primary care doctor.

Diabetes is a disease that requires attention. The Patient is ultimately responsible. We cannot make you do anything that you don't want to do – all we can do is give you advice. And we "cannot go home with you" – you must take care of things, 24/7.

Our goal is therefore NOT TO TREAT your diabetes but to TEACH you how to treat it and to troubleshoot it in the future. We are always here to help in case you have a problem, but our goal is to make it so you almost never need us.

When you come here for specialty diabetes care, you are not just coming to see a doctor; you will be treated by the full MNPG Diabetes Team. The responsibility of the MNPG Diabetes Team is to give you advice and skills to live well with diabetes. The team members have different expertise to help you with this 24/7 responsibility. At each visit you will therefore see one or more different team members based on what you or we think you need at that time. The diabetes doctor may not always be included, but the whole MNPG Diabetes Team is always behind you.

We are living in the middle of a diabetes epidemic. We strive to help as many patients with diabetes as we can and to do so we ask each patient's PRIMARY DOCTOR to help as much as possible. If you are doing well, we may ask you to come back to see us only if you have a problem and to work with your primary doctor most of the time. However, remember that we are always here for you even if we had not seen you for a number of years.

Date: _____

MOUNT NITTANY
PHYSICIAN GROUP

Diabetes Patient Questionnaire

In the sections that follow, please provide the requested information. Be as complete as possible.

PAST MEDICAL HISTORY

Please list any significant medical problems, which have required a doctor's care. Include any hospitalizations and dates.

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

PAST SURGICAL HISTORY

Please list any surgical procedures, which have been performed and their dates.

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

MEDICATIONS

Please list all medications that you are currently taking. Include the dosages and how many times you take them daily. ***INCLUDE SUPPLEMENTS, HERBAL PREPARATIONS, ETC.***

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____
10 _____
11 _____
12 _____
13 _____
14 _____
15 _____

ALLERGIES

Please list any allergies to medications and the reaction that occurred.

Medication	Reaction

Date: _____

SOCIAL HISTORY

Do you use tobacco products? ☐ Yes ☐ No

If so, do you smoke: ☐ filtered cigarettes ☐ non-filtered cigarettes ☐ cigars

Do you use: ☐ chewing tobacco ☐ snuff

How much per day? _____

How many years have you used tobacco products? _____

Do you drink alcohol? ☐ Yes ☐ No

If so, what type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Liquor

How much do you drink per day? _____ week? _____

What type of work do/did you do? _____

Are you: ☐ Married or in a stable relationship? ☐ Single? ☐ Divorced / Separated? ☐ Widowed?
☐ It's complicated...

FAMILY HISTORY

Please provide the requested information

Family Member	Age (if living or age at death)	Medical problems
Mother		
Father		
Sister/Brother #1		
Sister/Brother #2		
Sister/Brother #3		
Sister/Brother #4		
Sister/Brother #5		
Sister/Brother #6		
Mother's Mother		
Mother's Father		
Father's Mother		
Father's Father		
Aunt/Uncle #1		
Aunt/Uncle #2		
Aunt/Uncle #3		
Aunt/Uncle #4		
Aunt/Uncle #5		
Aunt/Uncle #6		

Date: _____

Men

How many children do you have? _____

Women -MENSTRUAL HISTORY

Please provide the requested information regarding your menstrual cycles.

Age when you had your first period? _____

Aside from perhaps the first few, have your periods been fairly regular? ☐ Yes ☐ No

Are you still having periods? ☐ Yes ☐ No

If your periods have been regular...

How many days between cycles (from the first day of bleeding of one period to the first day of bleeding of the next)? _____

How many days of bleeding do you normally have? _____

Characterize your bleeding/flow: ☐ Light ☐ Moderate ☐ Heavy

First day of your last menstrual period? _____

If your periods have been irregular...

How frequently do you have menstrual bleeding?_____

Have your periods always been irregular? ☐ Yes ☐ No

If no, when did this change occur?_____

Have your periods stopped completely? ☐ Yes ☐ No When? _____

OBSTETRICAL HISTORY

Please provide the following information regarding your pregnancies.

How many pregnancies have you had? _____

Number of live births? _____

Number of miscarriages? _____ Abortions? _____

Pregnancy#	Age at time of pregnancy	Delivery method (vaginal or C-section)	Delivery at # weeks gestation	Sex and weight of Infant	Complications during pregnancy or delivery
1					
2					
3					
4					
5					
6					

Date: _____

REVIEW OF SYSTEMS

Please circle items, which are of concern to you or have been bothersome to you.

GENERAL
Weight gain
Weight loss
Night sweats
Fatigue
Weakness
Fever
Shaking chills
Sweating

HEAD AND NECK
Vision changes
Double vision
Blurry vision
Flashing lights
Eye Pain
Redness of the eyes
Watery/Dry eyes
Hearing loss
Ringing in the ears
Ear pain
Discharge from the ear
Nasal congestion
Nasal discharge
Post-nasal drip
Nosebleeds
Sore throat
Hoarseness
Ulcers/sores in mouth
Tooth problems
Neck pain/stiffness
Dizziness
Room spinning

HEART/CARDIOVASCULAR
Shortness of breath at rest
Shortness of breath with exertion
Waking at night short of breath
Sleeping propped up sitting up
Leg cramps at night
Racing heart/palpitations
Irregular heartbeat
Swelling of the legs/ankles
Lightheadedness/dizziness
Leg cramps while walking
Chest pain at rest
Chest pain with exertion
High blood pressure
Fainting

LUNGS/PULMONARY
Chronic cough
Coughing up blood
Sputum/phlegm production
Wheezing
History of pneumonia
Pain when taking deep breaths
Sneezing
Frequent chest colds or bronchitis

GASTROINTESTINAL
Chronic abdominal pain
Nausea
Vomiting
Vomiting blood
Vomiting bile
Heartburn/acid reflux
Excessive belching/burping
Painful swallowing
Food/liquids getting stuck when swallowing
Constipation
Diarrhea
Dark appearing stools
Light appearing stools
Blood in stools
Painful bowel movements
History of liver problems
Jaundice
Loss of appetite
Hemorrhoids
Abdominal bloating

URINARY
Frequent urination
Infrequent urination
Incomplete voiding
Urine stream difficult to start
Urine cuts off in midstream
Frequent urination at night
Blood in urine
Pain with urination
Foamy appearing urine
History of UTIs
Leakage of urine
Passage of kidney stones
Bedwetting
Pain in kidney area

MALE GENITAL
Prostate problems
Inability to attain or maintain an erection
Discharge from penis
Swelling/lump in testicles
Pain in testicles
Changes in testicular size

MUSCULOSKELETAL
Joint pain
Joint stiffness
Muscle cramping
Muscle aches
Weakness-generalized
Back pain

NEUROLOGIC
Numbness or tingling of extremities
Weakness of arm/leg
Change in walking
Slurred speech
Blurred vision
Muscle twitches/jerking
History of seizure
Loss of consciousness
History of stroke
Tremor
Depression
Anxiety
History of mental illness
Memory loss

HEMATOLOGIC
History of anemia
Easy bruising
Easy bleeding
History of blood clots
History of blood transfusion
History of transfusion reaction

ENDOCRINE/HORMONAL
Excessive thirst
Excessive hunger
Excessive urination
Heat/cold intolerance
Thinning of skin
Purple stretch marks
Change in skin color
Craving for salt/iced drinks

Thank you very much for taking the time to provide this information. This information will be used to help us focus on current or potential medical problems.

Mount Nittany Physician Group,
1850 East Park Avenue,
State College, PA 16803

Phone: 814-234-8800 Fax: 814-234-8068

Date: _____

PAID (Identifying Your Problem Areas in Diabetes)

Directions: Living with diabetes can sometimes be quite difficult. In day-to-day life, there may be numerous problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are a variety of potential problem areas which people with diabetes may experience. From your own view, consider the degree to which each of the listed items may currently be a problem for you and circle the appropriate number.

If an item does not apply to you (e.g. "Currently coping with complications", and you don't have any), please circle "0".

Please note that we are asking you to indicate the degree to which each item may be bothering you in your life, NOT whether the item is merely true for you. For example, if you are "currently coping with complications", you would not necessarily rate this item with a high number. If you felt that this was not a bother or a problem for you, you would circle "0". If this was very bothersome to you, you might circle "5".

To what degree are the following issues currently problematic for you:	Not a problem					Serious problem
1. Not having clear and concrete goals for your diabetes care?	0	1	2	3	4	5
2. Feeling discouraged with your diabetes regimen?	0	1	2	3	4	5
3. Feeling scared when you think about having and living with diabetes?	0	1	2	3	4	5
4. Uncomfortable interactions around diabetes with family, friends, acquaintances who do not have diabetes? (e.g. a friend advising you on what to eat)	0	1	2	3	4	5
5. Feelings of deprivation regarding food and meals?	0	1	2	3	4	5
6. Feeling depressed when you think about having and living with diabetes?	0	1	2	3	4	5
7. Not knowing if the mood or feelings you are experiencing are related to your blood sugar levels?	0	1	2	3	4	5
8. Feeling overwhelmed by your diabetes regimen?	0	1	2	3	4	5
9. Worrying about low blood sugar reactions?	0	1	2	3	4	5
10. Feeling angry when you think about having and living with diabetes?	0	1	2	3	4	5
11. Feeling constantly concerned about food and eating?	0	1	2	3	4	5
12. Worrying about the future and the possibility of serious complications?	0	1	2	3	4	5
13. Feelings of guilt or anxiety when you get off track with your diabetes management?	0	1	2	3	4	5
14. Not "accepting" your diabetes?	0	1	2	3	4	5
15. Feeling unsatisfied with your relationship with your diabetes physician?	0	1	2	3	4	5
16. Feeling that diabetes is taking up too much of your mental and physical energy every day?	0	1	2	3	4	5
17. Feeling alone with diabetes?	0	1	2	3	4	5
18. Feeling that your friends and family are not supportive of your diabetes management efforts?	0	1	2	3	4	5
19. Coping with complications of diabetes?	0	1	2	3	4	5
20. Feeling "burned out" by the constant effort to manage diabetes?	0	1	2	3	4	5

Date: _____

HAD Scale

This questionnaire is designed to help us know how you feel. Please read each statement and mark one of the boxes indicated with ✓, which comes closest to **how you have been feeling in the past week.**

		✓					✓		
1. I feel tense or wound up:	Most of the time		3		8. I feel as if I am slowed down:	Nearly all of the time			3
	A lot of the time		2			Very often			2
	Time to time, occasionally		1			Sometimes			1
	Not at all		0			Not at all			0
2. I still enjoy the things I used to enjoy:	Definitely as much			0	9. I get a sort of frightened feeling like butterflies in my stomach:	Not at all		0	
	Not quite as much			1		Occasionally		1	
	Only a little			2		Quite often		2	
	Hardly at all			3		Very often		3	
3. I get a sort of frightened feeling as if something awful is about to happen:	Very definitely and quite badly		3		10. I have lost interest in my appearance:	Definitely			3
	Yes, but not too badly		2			I don't take so much care as I should			2
	A little, but it doesn't worry me		1			I may not take quite as much care			1
	Not at all		0			I take just as much care as ever			0
4. I can laugh and see the funny side of things:	As much as I always could			0	11. I feel restless as if I have to be on the move:	Very much indeed		3	
	Not quite so much now			1		Quite a lot		2	
	Definitely not so much now			2		Not very much		1	
	Not at all			3		Not at all		0	
5. Worrying thoughts go through my mind:	A great deal of the time		3		12. I look forward with enjoyment to things:	As much as ever I did			0
	A lot of the time		2			Rather less than I used to			1
	From time to time but not too often		1			Definitely less than I used to			2
	Only occasionally		0			Hardly at all			3

Date: _____

6. I feel cheerful:	Not at all			3	13. I get sudden feelings of panic:	Very often indeed		3	
	Not often			2		Quite often		2	
	Sometimes			1		Not very often		1	
	Most of the time			0		Not at all		0	
7. I can sit at ease and feel relaxed:	Definitely		0		14. I can enjoy a good book or radio or TV programme:	Often			0
	Usually		1			Sometimes			1
	Not often		2			Not often			2
	Not at all		3			Very seldom			3
		✓					✓		
	A	D							

Date: _____

Jan S. Ulbrecht, M.D.
Diabetes, Endocrinology and Metabolism

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Blood Glucose Monitoring Sheet

		Blood Glucose Value								Insulin/Medication Dose				Comments
		Breakfast		Lunch		Dinner		Night		B'fast	Lunch	Dinner	Bed	
Day	Date	Before	After	Before	After	Before	After	Bed	Sleep					
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														

Date: _____

Typical Days

Food **Activity** **Work** **Sleep** **DM Meds** **Insulin**								
	12:00 AM	**3:00 AM**	**6:00 AM**	**9:00 AM**	**12:00 Noon**	**3:00 PM**	**6:00 pm**	**9:00 pm**

Food **Activity** **Work** **Sleep** **DM Meds** **Insulin**								
	12:00 AM	**3:00 AM**	**6:00 AM**	**9:00 AM**	**12:00 Noon**	**3:00 PM**	**6:00 pm**	**9:00 pm**