IDAHO DIABETES

INTERVAL OFFICE EVALUATION NOTE

(Patient to Fill Out Before Physician Portion of the Visit)

Date: _____ Name: _____

Are there any questions you wished answered for this visit? ☐ YES ☐ NO

If so, list: _____

List your current medications (including over-the-counter medications):

Name	Dose	Frequency	Refill needed?
			Y OR N
			Y OR N
			Y OR N
			Y OR N
			Y OR N
			Y OR N
			Y OR N
			Y OR N

Which pharmacy would you like your prescriptions sent to?

Pharmacy: _____ Address: _____

Since your last visit have you seen another physician or health care provider? ☐ YES ☐ NO

Physician Name: _____Date of Visit: _____

Condition: _____

Have there been any interval changes in your family history or social situation since you were last seen (e.g., new diagnoses in family members, family death, divorce/marriage, change in insurance information, job change, etc.)?

☐ YES ☐ NO

If yes, please describe: _____

Do you currently have any of the following symptoms or conditions? (circle if yes)			
Abdominal Pain	Anemia or Bruising	Arthritis or Joint Pain	Change in Bowel Habits
Cancer	Chest Pain	Shortness of Breath	Convulsion or Seizure
Diarrhea/Constipation	Headaches/Migraine	Leg Pain with Exercise	Nervousness or Depression
Numbness or Tingling	Blood in Stool	Stroke	Urination Difficulties
Change in Vision	Weight Loss	Nosebleeds	Foot Sores or Skin Lesions
Dizziness or Fainting	Foot Pain	Jaundice or Yellowing	Thyroid Disease
Pregnancy	Planning Pregnancy	Menstrual Irregularity	Breast Discharge
Flushing	Hot Flashes	Other: _____	Other: _____