



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#:

Responsible Party

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

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

	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										

Type of Cancer:

Medical / Family History Form

*Additional fields if needed

Medications

Current Medications

[illegible]

Insulins

[illegible]

Medical / Family History Form
 *Additional fields if needed
Allergies

*Additional fields if needed

Allergies

Please list any allergies you have to medications

<u>Medication</u>	<u>Reaction</u>

Currently Receiving Treatment For

[illegible]

Hospitalization or Surgery

[illegible]