dNav® by HYGIEIA CARE CENTER

Patient Intake Form

PATIENT INFORMATION

Name	Prefix	First	Middle	Last	Suffix

Date of Birth	/ /	Height	_____ feet _____ inches	Weight	_____ lbs.

Gender	☐ Male ☐ Female ☐ Unspecified	Ethnicity	☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race	☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ White ☐ Other		
Do you smoke?	☐ Yes How long? _____ ☐ No	Years of education after high school?	#

Allergies?	

Home Address	Address	Apt. #	City	State	Zip

Home Phone #		Cell Phone #		Preferred Phone	☐ Home ☐ Cell
Permission to text?	☐ Yes ☐ No	Best time to reach you?			

Email Address		CareView ID #	

PHYSICIAN INFORMATION

Primary Care Physician

Name		Phone #	
Practice Location			

Endocrinologist or ANY other provider caring for your diabetes

Name		Phone #	
Practice Location			

PHARMACY INFORMATION

Name		Phone #	
Address			

INSURANCE INFORMATION

Primary Insurance		Group #		Contract #	
Secondary Insurance		Group #		Contract #	

Patient Intake Form

PATIENT DIABETES INFORMATION	
Diabetes type	☐ Type 1 ☐ Type 2

List all diabetes medication(s) you are currently taking:

Diabetes Medication Name #1 (include any notes)	
Diabetes Medication Name #2 (include any notes)	
Diabetes Medication Name #3 (include any notes)	
Diabetes Medication Name #4 (include any notes)	

Diabetes Complications

Have you ever suffered from:

1.	Diabetes related eye diseases, also called diabetic retinopathy?	☐ Yes ☐ No
2.	Diabetic kidney disease, such as kidney failure or protein/albumin in the urine, also called Diabetic Nephropathy or Albuminuria?	☐ Yes ☐ No
3.	Diabetic nerve damage, also called Diabetic Neuropathy?	☐ Yes ☐ No
4.	Coronary Artery Disease, such as heart attacks, coronary bypass graft surgery, coronary balloon or stents procedures?	☐ Yes ☐ No
5.	Heart failure?	☐ Yes ☐ No
6.	History of stroke?	☐ Yes ☐ No
7.	Peripheral Artery Disease, such as artery narrowing in the legs?	☐ Yes ☐ No
8.	Hypertension or High Blood Pressure?	☐ Yes ☐ No
9.	Dyslipidemia/Hyperlipidemia or being treated with medication to lower your cholesterol or triglycerides?	☐ Yes ☐ No

Patient Signature _____ Date _____

Witness _____ Date _____