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RXPERT USA

Personal Information Form

Please complete and BE SURE to be accurate….. Your report depends on it……

1 of 4

DIABETICS:

Number of years with diabetes: _____

Please enter fingerstick values:

DAY	*AM*	*NOON*	*A'NOON*
1	____	____	____	____
2	____	____	____	____
3	____	____	____	____
4	____	____	____	____
5	____	____	____	____
6	____	____	____	____
7	____	____	____	____

EVENINGS

Are you on a special diet? YES NO No

Do you have any numbness in your hands or feet? YES NO

If YES please explain and describe: No

_____

_____

Do you ever have dizzy spells? YES NO

If YES please explain and describe: Yes

_____

_____

Have you fallen from these spells? YES NO

If YES please explain and describe: No

_____

_____

Do you have periods during the day when you feel exhausted, weakness, washed out, about to faint? YES NO

If YES please explain and describe: No

_____

_____

Do you have trouble getting sores or wounds to heal? YES NO

If YES please explain and describe: No

_____

_____

FALLS:

Have you had any falls this year? YES NO (if YES how many) _____ Please list:

Yes

1. Time of day: _____ How long after taking your medicine: _____ What happened: _____

_____

_____

2. Time of day: _____ How long after taking your medicine: _____ What happened: _____

_____

_____

3. Time of day: _____ How long after taking your medicine: _____ What happened: _____

_____

_____

4. Time of day: _____ How long after taking your medicine: _____ What happened: _____

_____

_____

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2 of 4

DIGESTION:

Do you ever have indigestion or heartburn? YES NO *if YES* When?_____ How often? _____

How do you treat the heartburn/indigestion? _____

When you lie down in bed do you ever have burning in your chest or have stomach juices come up in your throat? YES NO if YES. How often? _____ Please explain _____

_____

How do you treat this problem? _____

Do you ever have diarrhea? YES NO if YES how often? _____

When does the Diarrhea start? _____ Ever start after taking any medicines? YES NO

Do you ever get constipated? YES NO if YES how often? _____ Does it ever happen after taking any medications? YES NO if YES please explain _____

How much fluid do you drink a day? Coffee _____ ounces Tea _____ounces Sodas _____ ounces

Do you drink alcoholic beverages? YES NO if YES what type BEER ____ LIQUOR ____ Amounts per day _____

Do you consume dairy products? YES NO if YES Amounts MILK_____ BUTTERMILK_____ CHEESE _____

Do you drink fruit juices? YES NO if YES Amounts ORANGE _____ LIME_____GRAPEFRUIT_____ GRAPE____

Do you eat three meals a day? YES NO if NO please explain_____

_____Do you snack during the day and at night? YES NO if YES what

do you eat _____ How much do you eat at a time _____

How often do you snack _____ Are you worried about your weight? YES NO

MOOD:

1. Are you basically satisfied with your life? YES NO
2. Have you dropped many of your activities or interests? YES NO
3. Do you feel that your life is empty? YES NO
4. Do you often get bored? YES NO
5. Are you in good spirits most of the time? YES NO
6. Are you afraid that something bad is going to happen to you? YES NO
7. Do you feel happy most of the time? YES NO
8. Do you often feel helpless? YES NO
9. Do you prefer to stay home, rather than going out and doing new things? YES NO
10. Do you feel that you have more problems with memory than most? YES NO
11. Do you think it is wonderful to be alive? YES NO
12. Do you feel pretty worthless the way you are now? YES NO
13. Do you feel full of energy? YES NO
14. Do you feel that your situation is hopeless? YES NO
15. Do you think that most people are better off than you are? YES NO

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3 of 4

PAINS:

Do you suffer from any type of chronic pain? YES NO if YES do you suffer daily? YES NO if YES where? _____

_____ What causes the pain? _____

_____

Do your muscles ache or twitch? YES NO if YES explain _____

_____

Do your joints ache? YES NO if YES explain _____

_____

Does your head hurt often? YES NO if YES how often? _____ Where does it hurt? _____

Does your stomach ache often? YES NO if YES how often? _____

On a scale of 1(low) to 10 (severe) what level is your pain? _____

Do you have any kind of daily exercise routine? YES NO.. If YES what kind? _____

If NO why not? _____

After exercising do your legs hurt? YES NO if YES how badly?_____ How long?_____ Where do they hurt the most? _____ Does your back hurt? YES NO if YES where? _____

Is there any type of movement or activity that you don't do because you know it will make you hurt? YES NO

If YES what? _____ Why? _____

_____

ANXIETY:

Do you have difficulty going to sleep at night? YES NO if YES what do you think is the reason? _____

_____

Do you worry a lot that something bad is going to happen to you or your family? YES NO if YES what problems do you believe are going to happen? _____

What makes you feel like this? _____

Do children get on your nerves? YES NO Does your spouse get on your nerves? YES NO

Does watching TV make you nervous? YES NO if yes what kind of TV do you like to watch? _____

_____

What do you like to do to relax? _____

Do you take naps during the day? YES NO if YES explain _____

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4 of 4

EDEMA:

Do your hands ever swell? YES NO if YES when _____ how much _____

Do your feet or legs ever swell? YES NO if YES when _____ how much _____

Does one side swell more than the other? YES NO if YES which side _____ how much _____

When you lie down in bed at night do you ever feel like you are smothering or can't get your breath? YES NO

If YES does sitting up or propping up with a pillow give relief? _____

If YES how often does this happen? _____

How much fluid on an average do you drink per day (any fluids) ? _____ ounces

COGNITION:

Do you find it hard to remember to do things that you are asked to do? YES NO if YES why? _____

_____

When going somewhere do you sometimes loose sense of direction and have to stop and think which way to go?

YES NO if YES please describe in detail _____

_____

Do you ever forget to take your medicine? YES NO if YES explain: _____

_____

What day is today? _____ What is today's date? _____ Month? _____

Do you get nervous in crowds of people? YES NO Do you like to go to Church? YES NO

Do you always get a good night's sleep? YES NO if NO explain: _____

_____

Do you feel just as tired when you wake up as you did when you went to bed? YES NO

If YES explain: _____

_____

Do you like meeting new people and talking to them? YES NO if NO why? _____

How have you made your living? _____

_____

Did you like your work? YES NO explain: _____

_____

Make sure all questions are answered… Thank you……..