

# MedicationXpert.com

## Personal Information Form

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

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### DIABETICS:

Number of years with diabetes: \_\_\_\_\_

#### EVENINGS

Are you on a special diet? YES NO

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

If YES please explain and describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you ever have dizzy spells? YES NO

If YES please explain and describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please enter fingerstick values:

DAY	AM	NOON	A'NOON
-----	----	------	--------

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

Have you fallen from these spells? YES NO

If YES please explain and describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

If YES please explain and describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### FALLS:

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

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

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**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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### 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.....**