Name____________________________________ **Currently Using Insulin Pump/Dexcom/Libre? Y N**

Preferred Pharmacy/City/Street____

Circle "Y" for Yes if you have recently experienced any of the following symptoms, otherwise leave blank

General/Constitutional

Fever Y
Weight gain Y
Weight loss Y

Ophthalmologic/Eyes

Blurred vision Y
Eye pain Y

ENT (Ear/Nose/Throat)

Difficulty swallowing Y
Sore throat Y

Endocrine

History of radiation to the head or neck Y
Cold intolerance Y
Excessive thirst Y
Heat in tolerance Y

Respiratory

Shortness of breath Y
Cough Y
Wheezing Y

Cardiovascular

Chest pain Y
Dizziness on standing Y
Fluid accumulation in legs Y
Palpitations Y

Gastrointestinal

Abdominal pain Y
Constipation Y
Diarrhea Y
Heartburn Y
Nausea Y
Vomiting Y

Hematology/Blood

Easy bruising Y
Prolonged bleeding Y

Women

Decline in sexual desire Y
Heavy bleeding during menses Y
Hot flashes Y
Irregular menses Y
Missed periods Y

Men

Low sex drive Y
Erection problems Y

Genitourinary

Frequent urination Y
Painful urination Y

Musculoskeletal

Muscle aches Y
Painful joints Y

Podiatric/Feet

Foot numbness Y
Foot pain Y

Skin

Hives Y
Rash Y

Neurologic

Headache Y
Tremor Y

Psychiatric

Anxiety Y
Depressed mood Y

Additional Comments: