NAME: _____ DOB: _____ DATE _____

When did you first learn you had diabetes? _____

Does anybody in your family have diabetes? YES NO Who? _____

List hospitalizations for diabetes:

Month/year	Where	How Long	Why

When first treated for diabetes, what medications did you take? _____

Are you presently taking pills for your diabetes? YES NO

Name of pill	Dose	How often

Doses changed recently? YES NO Explain: _____

Are you presently taking insulin? YES NO Type(s) of insulin: (circle)

70/30 *Novolog Mix*	LISPRO *Humalog*	ASPART *Novolog*	GLULISINE *Apidra*	DETERMIR *Levemir*	GLARGINE *Lantus*	REGULAR	NPH	70/30 *Novolin*

Name of insulin	Dose	Time(s)

Insulin dose changed recently? YES NO Explain _____

Adjust your insulin yourself? YES NO How? _____

Use insulin syringes? YES NO Size _____ For what insulin? _____

Use an insulin pen? YES NO For what insulin? _____

Give your own shot? YES NO

Do you use an insulin pump? YES NO PLEASE LIST: Basal infusion rate and dosage schedule

APPLY PATIENT LABEL HERE

MR

DIABETES SELF MONITORING

(Always bring self-monitoring records/meter with you each visit)

Do you test your blood sugar at home?_____ How often each day? _____

If yes, what meter do you use? *Freestyle* *One Touch Ultra* *Accu-Chek* *Contour* ***other*** _____

	TIME OF TESTING	RESULTS (average or range)
Before Breakfast	_____	_____
Before Lunch	_____	_____
Before Dinner	_____	_____
Before Bedtime	_____	_____
Other Times	_____	_____

Do you adjust your insulin on the basis of these tests? YES NO

DIETARY AND WEIGHT HISTORY

Height _____ Present Weight _____

Have you recently (circle) lost gained How much ? _____ Over what period of time? _____

After age 20, what was your highest weight? _____ Age? _____

Ever been instructed to follow a specific diet by a dietitian? YES NO When? _____

Estimated calories you eat daily? _____

Dietary restrictions? (circle) SALT CHOLESTEROL SUGAR FAT PROTEIN NONE other _____

Do you count carbs? YES NO

Who prepares your food?

Do you binge on food? Type of food?

How often do you eat at restaurants? What meals? _____

Meal patterns different on weekends? YES NO

Work schedule interfere with meals? YES NO How? _____

Ethnic preference in food? _____ What kind? _____

Do you drink alcohol? _____ When? _____ How much? _____ What kind? _____

EXERCISE

Describe your exercise program:

Physical impairment preventing exercise? YES NO Describe: _____

APPLY PATIENT LABEL HERE

MR

PROBLEMS ASSOCIATED WITH DIABETES

Have you experienced ***HYPOGLYCEMIA*** (low blood sugar reaction)?

NEVER OCCASIONALLY ONCE A WEEK ONE OR MORE TIMES DAILY

What time of day? ______________________ Symptoms? ____

How do you treat reactions? ____

DIABETIC RETINOPATHY (eye problems)

Eye doctor's name______________________ Date of last eye exam ____________________________________

Has diabetes affected your eyes? YES NO CATARACTS HEMORRHAGES GLAUCOMA OTHER __________

Do you have limited vision? YES NO Which eye? LEFT RIGHT BOTH

Have you had laser treatments? YES NO

Do you have ***DIABETIC NEUROPATHY*** *(nerve problems)*? YES NO

	Hands	Arms	Feet	Legs	Other ________
Pain, Numbness, Tingling	________	________	________	________	________
How long ?	________	________	________	________	________

Other symptoms ____

Get dizzy or faint on standing too rapidly? YES NO

Have unexplained, severe diarrhea? YES NO

Have unexplained vomiting or undigested food? YES NO

Have excessive or lack of sweating? YES NO

DIABETIC NEPHROPATHY *(kidney problems)*

Have you been told diabetes has affected your kidneys? YES NO

Do you ever have kidney or bladder infections? YES NO How often? ____________________________________

VASCULAR DISEASE *(circulation problems)*

Have you been told your cholesterol or triglycerides levels are high? YES NO

Have you ever had a heart attack? YES NO

Do you have leg pain when walking? YES NO How far walking before pain begins.________________

Do you have sores that are not healing? YES NO Where?____________________________________

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DIABETES EDUCATION

Have you participated in a diabetes education program? YES NO

Where? ______________________________ When? ____

Judge your diabetes knowledge: COULD BE BETTER ADEQUATE VERY GOOD KNOW IT ALL

What are your greatest concerns about diabetes? ____

APPLY PATIENT LABEL HERE

MR