DIABETES ASSOCIATES MEDICAL GROUP-DIABETES QUESTIONNAIRE

PATIENT NAME: **DOB:**

<u>SYMPTOMS-Describe and circle the correct answer:</u>

Date or year of diagnosis of diabetes-------------------Age at diagnosis------------------------
Year started on oral diabetes pills----------------------Year started on insulin-----------------
What is your usual A1c---------------------------------What is your latest A1c-----------------
How many times have you been in hospital for diabetes emergency? Low glucose (Hypoglycemia)-------------diabetic ketoacidosis(DKA)-------------- Coma-----------------
Do you have high glucose that started in pregnancy(GDM)------ yes/no? Have you started the sweet beginnings program--------- yes/no? Are you on a diet------- yes/no?- Are you on Metformin- yes/no? Are you on Insulin------ yes/no?
When was last period-------------Due date ------------- How many weeks pregnant---------
Did you have a past history of GDM--yes/no Treated with diet--- yes/no Treated with Metformin----------yes/no Treated with insulin---------yes/no?
Have you had Toxemia of pregnancy--yes/no Hypertension in pregnancy----yes/no? proteinuria in pregnancy-- yes/no?
Have you had > one miscarriage--yes/no Stillbirth----yes/no Preterm labor----yes/no Delivered a baby >9 lb--- yes/no?
Do you urinate frequently in the day---yes/no?(how many times)--- Wake up at night to urinate-----yes/no?--- (how many times)------
Do you have abnormal thirst------------------yes/no? constant hunger-----------------yes/no?
Do you have unexplained weight loss-------yes/no? unexplained weight gain-------yes/no?
Have you had known complications due to diabetes-----------------------------------yes/no?
Have you seen a cardiologist- yes/no Had an ECHO-------- Had a stress test--------yes/no?
Was the stress test abnormal--- yes/no? ----- Do you have a pacemaker------------ yes/no?
Do you have congestive heart failure(CHF)--- yes/no? Heart murmur------------- yes/no?
Have you had angina------- yes/no ----- heart attack(MI)---- yes/no What Year-------------
Have you had a coronary stent----- yes/no What Year ------- How many vessels stented---
Have you had CABG----- yes/no What Year -------------How many vessels------------------
Have you had a stroke(CVA)-------------yes/no What Year-----------TIA-------------yes/no?
Has the diabetes affected your kidneys--yes/no?
Do you have kidney failure--------yes/no? Do you have protein in urine----------- yes/no?
Are you on dialysis-------yes/no? PD/hemodialysis. How many years on dialysis----------?
Have you had a kidney transplant-----yes/no? What year did you receive the kidney transplant--------------------? Was it cadaver donor----yes/no? living donor---------Yes/no?
Have you had a second kidney transplant-----yes/no? What year did you receive the second kidney transplant----------? Was it cadaver donor--- yes/no? living donor--yes/no?
Do you have blurred vision----------yes/no? See colored halos around lights-------yes/no?
Do you have diabetic retinopathy------yes/no? Do you have glaucoma--------------yes/no?
Do you have cataracts--------yes/no? Do you have macular degeneration-----------yes/no?
Have you had cataract extraction--------yes/no? Have you had lens implants--------yes/no?
Have you had laser eye surgery------------yes/no? Have you had vitrectomy--------yes/no?
Have you had bleeding in the back of the eye----yes/no? Retinal detachment----- yes/no?

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When did your eye doctor last examine your eyes--?
Do you have skin problems--------- yes/no?- Do you have skin ulcer----------------yes/no?
Do you have numbness/tingling of the feet-- yes/no? Of the hands----------------yes/no?
Do you have burning pain of the feet--yes/no?----- Burning pain of the hands------yes/no?
Do you have foot problems---yes/no?
Do you have leg cramps while walking-----yes/no? Leg cramps when asleep------ yes/no?
Do you have leg cramps when you are resting---yes/no?
Have you been told you have poor circulation (PAD)---------------------------------yes/no?
Have you had bypass surgery to the right leg---------yes/no? To the left leg------yes/no?
Have you had an amputation---------------------------yes/no? What Year--------------------
Do you have swelling of the feet---yes/no?
When did you last see the podiatrist--
Do you easily get nauseated-----------yes/no? Do you vomit after eating-----------yes/no?
Do you get full rapidly when eating-------yes/no? Do you have gastroparesis-------yes/no?
How frequent are your bowel movements--
Do you have <u>unexplained</u> fatigue--yes/no?
Do you have erectile/sexual problems---yes/no?
Do you exercise regularly---yes/no?
If so, what type of exercise and for how long and how many times a week------------------
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What kind of diet do you follow---
About how many calories do you eat daily---?
Have you gone for diabetes education classes---yes/no?
Do you want to go for diabetes education classes--------------------------------------yes/no?
Do you check your blood sugars with a glucose meter--------------------------------yes/no?
What is the name of the glucose meter that you use--?
How many times a day do you check your blood sugar--?
What is your typical glucose range---?
How often do you get a reading less than 60 mg/dL? ---?
What time of day is your glucose the lowest--?
How often do you get a reading above than 200 mg/dL?--?
What time of day is your glucose the highest---?
Do you have symptoms of low blood sugar---yes/no?
What symptoms of low blood sugar do you have ---
--?
Do you no longer experience the early warning symptoms of low sugar------------yes/no?
What is the lowest reading you have had recently while feeling perfectly fine? ---------------?
How low does the reading have to be before you can feel your sugar is low? ------------------?
Have you had a seizure due to low blood sugar--yes/no?
Have you lost consciousness due to low blood sugar----------------------------------yes/no?
When was your last severe hypoglycemic reaction during which you required assistance from another person to bring your glucose up and how many times per year does this happen ?-----
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Do you frequently have nightmares--yes/no?
Do you have drenching night sweats --yes/no?

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How frequently do you have low sugar reactions---?
Has your drivers license being suspended due to loss of consciousness---------------yes/no
Do you have low blood sugar after exercise--yes/no?
Do you carry glucose tablets---yes/no?
Do you have Glucagon injection--yes/no? When was the last time you used glucagon -------
Do you have frequent infections---yes/no?
If so, what type of infections--?
Do you have slow healing ulcers--yes/no?
Do you have dental problems---yes/no?
If you use an Insulin pump, what type does you use--?
What year did you begin to use an insulin pump ---?
What are your basal Insulin rates---
--?
What is your carbohydrate ratio--

What is your correction factor--

If you use a continuous glucose sensor, what type does you use------------------------------?
Do you take steroids--yes/no?
Name and address of your pharmacy--
Are you on a mail order prescription plan(90 day prescriptions)------------------------------?
What is your pharmacy phone number--------------------Fax number-------------------------?
Does your insurance cover prescriptions written for 30 days or 90 days---------------------
Do you want to discuss gastric bypass surgery/lap band------------------------------ yes/no?
Do you want to discuss Medifast weight loss diet-------------------------------------- yes/no?
Do you want advice on anti-aging supplements-- yes/no?
Do you take the Flu shot annually-- yes/no?
What year was your last pneumonia vaccination---?
Please see the section on the website for **medication list** and fill out the form.
Please bring your blood sugar meter and blood sugar record to your appointment.
For 1-2 day prior to your visit, check your sugars 7 times a day (before each meal, 2 hours after each meal and at bedtime) and bring these numbers written down to your appointment. Please bring all of your medication bottles to your visit. Thank you!