

Diabetes

Name Male Female Age _____ Date of Birth _____

Tobacco Use No Cigarettes Other tobacco _____ Date quit? _____

State _____ Amount of Insurance _____ Type of Insurance _____

Occupation/Source of income: _____

1. Date that Diabetes was diagnosed: _____

2. How often do you visit your physician? _____

3. Diabetes is controlled by: _____

Diet alone, Oral Medication- type of medication and amount _____

Insulin- type and amount: _____ Insulin pump _____

4. Test results: _____ Date: _____ Date: _____ Date: _____ Date: _____

Fasting Blood Sugar _____

Random Blood Sugar _____

Hgb A1C _____

How often do you monitor your blood sugars? _____ Average blood sugars? _____

5. Do you have any of the following complications of diabetes:

- Neuropathy- mild, Neuropathy- moderate to severe,
- Retinopathy- mild, Retinopathy- moderate to severe,
- Kidney disease, Protein in urine,
- Hypertension,
- Coronary artery disease or other heart problems,
- Amputation.

Details of #5: _____

General Questions:

1. Do you have any other major health problems? No Yes – Details: _____

2. List all medications: _____

3. Height: _____ Weight: _____ Most recent blood pressure reading: _____