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Diabetes & Abnormal Glucose Questionnaire

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Patient Name/DOB: ____ Date: ______________________

Diabetic History

Have you been diagnosed with any of the following? ❒ Yes ❒ No

If yes, please choose below:

❒ Diabetes Mellitus Type 1 ❒ Hyperglycemia ❒ Gestational Diabetes ❒ Pre-Diabetes
❒ Diabetes Mellitus Type 2 ❒ Hypoglycemia ❒ Insulin Resistance ❒ Dysmetabolic Syndrome

Do you have any of the following? ❒ Yes ❒ No

❒ Abnormal Thirst ❒ Constant Hunger ❒ Frequent Urination ❒ Unexplained Weight Loss
❒ Unexplained Weight Gain ❒ Blurred Vision ❒ Unexplained Fatigue ❒ Tingling in Hands or Feet
❒ Numbness in hands or feet ❒ Burning Pain in hands or feet ❒ Erectile/Sexual Problems ❒ Slow Healing Ulcers
❒ Skin Problems ❒ Foot Problems ❒ See Halos Around Lights ❒ Frequent Nightmares
❒ Night Sweats ❒ Frequent Infections ❒ Frequent Bowel Movements ❒ Swelling of Legs or Feet

Do you have symptoms when your blood sugar is low? ❒ Yes ❒ No

If yes, what symptoms associated to low blood sugar do you get: ____

Recently, what is the lowest reading you have while feeling perfectly fine: ____

Typically how low is your blood sugar when you begin to feel symptoms: ____

How frequently do you have low blood sugar reactions: ____

After exercising, do you get low blood sugar? ❒ Yes ❒ No

Have you ever had a seizure due to low blood sugar? ❒ Yes ❒ No

Have you ever lost consciousness due to a low blood sugar? ❒ Yes ❒ No

Have you ever required assistance from another person to treat severe low blood sugar? ❒ Yes ❒ No

When was you last severe low blood in which you required assistance from another person, and how many time per year does this happen:
____

Has your driver's license ever been suspended due to loss of consciousness caused by low blood sugar? ❒ Yes ❒ No

Do you regularly carry glucose tablets? ❒ Yes ❒ No

Do you regularly carry a Glucagon Injector? ❒ Yes ❒ No

When was the last time you used a Glucagon Injector: ____

Do you currently check your blood sugar with a Glucose meter? ❒ Yes ❒ No

- What is the brand of the glucose meter: ____
- How many times per day do you check your blood sugar: ____
- What is your typical blood sugar range: ____
- How often do you get a reading less than 60 mg/dL: ____
- What time of day is your blood sugar the lowest: ____

- How often do you get a reading above than 200 mg/dL: ______________________________
- What time of day is your glucose the highest: ______________________________

For Diagnosed Diabetics

When were you diagnosed with Diabetes (if date is not known, year you were diagnosed): ______________________

- Your age at time of diagnosis: ______________

If you are currently taking oral Diabetes medication(s), what year did you start: ______________________

If you are on Insulin, what year did you start: ______________________________

What is your usual Hemoglobin A1c: __________ % What is your most recent A1c: __________ %

Have you ever been hospitalized for any of the following?

❒ Low Glucose ❒ Diabetic Ketoacidosis (DKA) ❒ Diabetic Coma

Do you have any known complications due to diabetes? ❒ Yes ❒ No

For Diabetics Using an Insulin Pump

What year did you begin using an Insulin Pump: ______________________________

What brand pump do you currently use: ______________________________

- What are your basal insulin rates: ______________________________
- What is your carbohydrate ratio: ______________________________
- What is your correction factor: ______________________________

Are you currently using a continuous glucose sensor, what brand do you use: ______________________

Heart, Kidney, Foot, & Eye

Have you seen a cardiologist: ❒ Yes ❒ No If yes, please make sure to list on Patient Physician List Form

Have you ever had an Echocardiogram (ECG/EKG): ❒ Yes ❒ No If yes, Date of last ECG: ______________

Have you ever had a Stress Test: ❒ Yes ❒ No If yes, Date of last Stress Test & was it Normal/Abnormal: ______________

Do you have a pacemaker: ❒ Yes ❒ No If yes, Date of implantation: ______________________

Do you have a history of the following:

❒ Heart Murmur ❒ Angina ❒Proteinuria ❒ Peripheral Artery Disease ❒ Congestive Heart Failure

Have you had any of the following:

❒Heart Attack ❒ Stroke (CVA) ❒ “Mini Stroke” (TIA)

Do you have any stents or grafts: ❒ Yes ❒ No If yes, which one and how many vessels:

❒ Coronary Stent: ________ Vessels ❒ Coronary Artery Bypass Graft: ________ Vessels

Do you have Kidney Failure: ❒ Yes ❒ No If yes, are you on Dialysis: ❒ Yes ❒ No

If on Dialysis, which type & for how many years now: ❒ Hemodialysis: ______ years ❒ Peritoneal Dialysis: ______ years

Have you had a Kidney Transplant: ❒ Yes ❒ No If yes, what year was the transplant: ______________

What kind of donor was it: ❒ Living ❒ Cadaver

When was your last foot exam: ______________________________

Do you frequently have leg cramps: ❒ Yes ❒ No If yes, when does it occur: ❒ While Walking ❒While Resting ❒While Asleep

Do you have a history of any of the following: ❒ Yes ❒ No

❒ Bleeding at the back of the eye ❒ Cataracts ❒ Cataract Extraction ❒ Diabetic Retinopathy ❒ Glaucoma

❒ Laser Eye Surgery ❒ Vitrectomy ❒ Macular Degeneration ❒Retinal Detachment ❒ Lens Implants

When was your last eye exam: ______________________________

Have you had any body part amputated: ❒ Yes ❒ No If yes, what was amputated & what year:________________________________

Do you experience any of the following: ❒ Yes ❒ No

❒ Easily Nauseated ❒ Vomiting After Eating ❒ Rapid Fullness When Eating

How frequent are your bowel movements: ____

Do you get frequent infections: ❒ Yes ❒ No

Do have dental problems: ❒ Yes ❒ No

Do you take steroids: ❒ Yes ❒ No

Do you get the Flu Shot annually: ❒ Yes ❒ No

What year was you last pneumonia vaccination: ____

Diet & Exercise

Do you exercise regularly? ❒ Yes ❒ No

What type of exercises: ❒ Walking ❒ Jogging ❒ Aerobics ❒ Bicycling ❒ Swimming ❒Sports ❒Other: ___________________

How many times a week do you exercise: ❒ 0 ❒ 1-2 ❒ 3-4 ❒ 5+

Approximate duration of exercise: ❒ 15 mins ❒ 30-45 mins ❒ 1 Hour ❒ 2+ Hours

What kind of diet do you follow: ____

About how many calories do you eat daily:____

Have you ever gone for diabetes education classes: ❒ Yes ❒ No

If no, would you like to go for diabetes education classes: ❒ Yes ❒ No

For Pregnant Females Only

When was your last menstrual cycle: ____________________________________ Due Date: ____________________________________

How many weeks pregnant are you: ____

Do you have high glucose that started during pregnancy (gestational diabetes): ❒ Yes ❒ No

Have you started the Sweet Beginnings program: ❒ Yes ❒ No

Are you currently on a diet to help control your blood sugars: ❒ Yes ❒ No

Are you taking Metformin: ❒ Yes ❒ No

Are you using insulin: ❒ Yes ❒ No

Do you have a history of gestational diabetes: ❒ Yes ❒ No

- Were you treated with diet: ❒ Yes ❒ No
- Were treated with metformin: ❒ Yes ❒ No
- Were you treated with insulin: ❒ Yes ❒ No

Have you had preeclampsia (pregnancy-induced high blood pressure): ❒ Yes ❒ No

Have you had proteinuria (protein in urine): ❒ Yes ❒ No

Do you have a history of any of the following:

❒ Miscarriage ❒ Stillbirth ❒ Preterm Labor ❒ Delivered baby >9lbs