Huntington Health Physicians

Diabetes Questionnaire

If you have diabetes, please complete the following questionnaire to the best of your knowledge.

Name: _____

Birthdate: ____/____/_____
(month) (day) (year)

DIABETES HISTORY

How long have you had diabetes?

_____

How is your diabetes controlled? ○Diet only ○Pills ○Insulin ○Both pills and insulin

Have you ever been told that you have any of these health problems associated with diabetes?

☐ Retinopathy (Eye problems) ☐ Neuropathy (Nerve problems)
☐ Nephropathy (Kidney problems) ☐ Foot problems
☐ High cholesterol ☐ High blood pressure

Have you ever been hospitalized/seen in the emergency room for diabetes? ○Yes ○No

If yes, please describe below:

_____ Dates: _____
_____ Dates: _____
_____ Dates: _____
_____ Dates: _____

DIABETES SELF-MANAGEMENT HISTORY

Do you test your blood sugar? ○Yes ○No How often do you test? _____

What machine/meter do you use? _____

What is your usual blood sugar level? _____ Last HbA1C level? _____

IF YOU TAKE INSULIN:

Type of Insulin	Dose	How often?

Where do you inject insulin? ☐Arm ☐Thigh ☐Abdomen ☐Buttocks ☐Other: _____

Do you have any problems with the injection site? ○Yes ○No

If yes, please describe: _____

IF YOU USE AN INSULIN PUMP:

How long have you been on pump therapy? _____

What pump do you use? _____ What infusion catheter? _____

How often do you change sites? _____

What are your basal rates? _____

What are your bolus settings? _____

GENERAL CARE

Date of last visit to your eye doctor: _____ Any vision problems? _____
How often do you see your dentist? _____ Dental/gum problems? _____
Do you check your feet daily? ○Yes ○No

ACUTE COMPLICATIONS

How often have you had low blood sugar in the last month? _____
What symptoms do you feel when your sugar is low? _____
At what blood sugar level do you have symptoms? _____
Have you lost consciousness from low blood sugar?○Yes ○No Needed assistance?○Yes ○No
How do you treat low blood sugar? _____
Do you carry simple sugar with you? ○Yes ○No Do you wear a medical alert ID? ○Yes ○No

DIABETES EDUCATION/SELF-MANAGEMENT TRAINING

Have you had education/self-management training for diabetes? ○Yes ○No
When and where? _____
What information and/or skills would you like to learn to help you better manage your health/ diabetes?

I certify that the foregoing statements are true to the best of my knowledge.

_____

Patient Signature