Pediatric Diabetes
Follow Up Intake Form

Appointment Date: _____ Patient Name_____

Patient's preferred name: _____ Date of birth: _____

Preferred Language: _____ Would you like an interpreter? _____

Who is here today with the patient? _____

Send records my PCP (name): _____ Other provider(s):_____

CLINIC USE ONLY		
	Previous Visit	Today's visit
Date		
Weight		
HgbA1C		

What matters to you today?	
Since your last visit with us, have you:	
Been in the emergency room or hospital?	□ No □ Yes:
Had surgery?	□ No □ Yes:
Had any major illnesses or injuries?	□ No □ Yes:
Missed time from school?	□ No □ Yes, how many days and why?
Had a family member diagnosed or treated for a new health problem?	□ No □ Yes:

Tell us about your diabetes:	
Do you remember your last HgbA1C?	Do you think your A1C today will be better, same or worse?
Brand of glucose meter your are using:	
If on an insulin pump, what brand:	How often do you change pump sites? Every ____ days.
Injection site or pump site locations:	□ Arms □ Legs □ Abdomen □ Bottom
If on a CGM, what brand?	CGM Location: □ Arms □ Legs □ Abdomen □ Bottom
Any pump or CGM issues?	□ No □ Yes:
Any moderate or large ketones since last visit?	□ No □ Yes. If yes, please explain:
Any severe low (less than 50) since the last visit?	□ No □ Yes. If yes, was glucagon given? □ No □ Yes
What blood sugar level do you feel low?	What do you feel when your are low:
How do you count carbohydrates?	□ Not at all □ Guess □ Estimate □ Accurate to the gram
When do you give your meal insulin dose?	□ Before Meals □ After meals
Do you wear a diabetes ID? □ No □ Yes	Do you have a medical ID on your phone? □ No □ Yes
Last eye exam:	Last dental exam:
What have you been doing well?	
What do you need to work on?	

PLEASE FILL OUT THE BACK OF THIS FORM.

Insulin doses: (COMPLETE ONLY IF YOUR ARE ON SHOTS)			
Which long acting insulin do you use: □ Lantus □ Basaglar, □ Levemir □ Tresiba? Dose and time:			
Do you use any of the following: □ Humalog □ Novolog □ Apidra or □ Admelog			
	Insulin to carb ratio	Correction/ insulin sensitivity, and BG target	How many units do you typically give?
Breakfast			
A.M. snack			
Lunch			
P.M. snack			
Dinner			
Bedtime			

Any changes to the medication list (include vitamins or supplements): □ No □ Yes: _____

Any new allergies? □ No □ Yes: _____

Other symptoms since your last visit: □ NONE		
□ Appetite change	□ Feeling too hot or too cold	□ Skin dryness or changes
□ Unusual tiredness	□ Belly pain	□ Skin irritation/ lumps on injection sites
□ Headaches	□ Constipation	□ Increased thirst or urination
□ Breathing issues	□ Frequent diarrhea	□ Wetting/ urine accidents
□ Sleep problems or snoring	□ Joint or muscle pain	□ Behavior change
□ Fast heart rate	□ Puberty changes	□ Anxiety
□ Chest pain	□ Irregular menstrual periods	□ Depression
□ Dental issues	□ Hair loss	□ Numbness or tingling
		□ Seizure

Social History	
Who lives at home with the patient?	
Any changes in the parents' marital status?	□ No □ Yes:
Any changes in parents' employment?	□ No □ Yes:
Any plans to move?	□ No □ Yes: Where? When?
Grade in school:	Any concerns in school □ No □Yes:
Sports or regular exercise?	□ No □ Yes:

Do you have prescriptions that need to be refilled? □ No □ Yes: _____

Name and location of your preferred pharmacy: _____

Phone number for the physician to reach you: _____

A few friendly reminders:

- Remember to change your insulin pen or vial every 30 days once your have opened it.
- Remember to store any unopened insulin in the refrigerator. Do not freeze. Once your insulin has been opened, they can stay at room temperature for 30 days.
- Remember to check the expiration date of your ketone strips. Once the canister has been opened, the strips are only good for 3 months.
- Glucagon expires based on the date on the actual kit, not on the pharmacy label.