Name:

Date: _____

Diabetes Pre-consultation Questionnaire

To provide you with the best care possible, we request that you provide the following information. Your answers on this form will help the doctor understand your medical conditions better and more promptly leaving more time to discuss your questions.

Year of diabetes diagnosis (or best estimate): _____

Diagnosis was: ☐ on routine testing ☐ after follow up of abnormal glucose ☐ after gestational diabetes

☐ testing due to symptoms of: _____

Glucose meter or sensor brand/model: _____

Last diabetes education (where/when): Classes: _____ Dietitian/DM educator: _____

PAST medications tried (current medication list to follow): ☐ None ☐ None other than insulin

☐ Metformin (Glucophage, Fortamet, Riomet, Glumetza)

☐ Glipizide (Glucotrol)	☐ Glimepiride (Amaryl)	☐ Glyburide (Micronase/DiaBeta)	
☐ Pioglitazone (Actos)	☐ Rosiglitazone (Avandia)		
☐ Sitagliptin (Januvia)	☐ Saxagliptin (Onglyza)	☐ Alogliptin (Nesina)	☐ Linaglipitin (Tradjenta)
☐ Dapagliflozin (Farxiga)	☐ Canagliflozin (Invokana)	☐ Empagliflozin (Jardiance)	☐ Ertugliflozin (Steglatro)
☐ Nateglinide (Starlix)	☐ Repaglinide (Prandin)	☐ Colesevelam (Welchol)	☐ Pramlintide (Symlin)
☐ Acarbose (Precose)	☐ Miglitol (Glyset)	☐ Bromocriptine (Cycloset)	
☐ Liraglutide (Victoza)	☐ Dulaglutide (Trulicity)	☐ Semaglutide (Ozempic/Rybelsus)	☐ Exenatide (Byetta, Bydureon)
☐ Detemir (Levemir)	☐ Degludec (Tresiba)	☐ Glargine (Lantus/Toujeo/Basaglar)	☐ NPH Insulin
☐ Lispro(Humalog/Admelog)	☐ Aspart (NovoLog/Fiasp)	☐ Glulisine (Apidra)	☐ Regular Insulin

☐ Other: _____

Known diabetes complications? Do you have any of the following potentially diabetes related problems:

☐ Eyes- regular eye exams by an eye specialist are recommended.

Your eye specialist: _____ Last seen (approx): _____

Any known diabetic eye problems? _____ Any history of retinal laser therapy?: _____

☐ Kidneys- in mild forms this may be called "spilling protein" or "albuminuria"

☐ Nerve Sensation- diabetes can affect the nerves to your hands and feet.

☐ Numbness or Tingling to your ☐ feet and/or ☐ hands

☐ Pains to your ☐ feet and/or ☐ hands. If so, types of symptoms (circle): Aching? Burning? Shooting pains?

☐ Do you perform routine self-foot exams? NO / YES

☐ History of skin ulcers on your feet? If yes when/where: _____

Extreme high or low blood sugar reactions

Have you needed medical assistance to treat or gone to the ER/hospital for high/low sugar or ketoacidosis (DKA)? ☐ No

☐ Yes (details- when/why) _____

_____

Do you have low blood sugar reactions: ☐ Yes ☐ No Lows ☐ Have low readings, but no symptoms

If yes, symptoms include: ☐ Sweating ☐ Shaking ☐ Palpitations ☐ Hunger ☐ Anxiety

☐ Visual Changes ☐ Mental cloudiness/ difficulty concentrating ☐ Fatigue

☐ How low is your blood glucose when you have symptoms? _____

☐ Other symptoms or details: _____

Do these lows occur at a particular time? ☐ After skipping a meal ☐ During / after exercise ☐ Overnight ☐ Randomly

☐ Other times or details: : _____

About how frequently do these episodes occur? (ie once/day, 2/week): _____

How do you treat lows? ☐ Food ☐ Juice ☐ Candy ☐ Glucose Tablets ☐ Other: _____

Do you carry glucose tablets with you when out of the house NO / YES

Do you have a: ☐ Medic Alert Bracelet ☐ Medic Alert Pendant ☐ Glucagon Emergency Kit (Glucagon/Glucagen/Baqsimi/Gvoke)

PERSONAL MEDICAL HISTORY (indicate if you have the following with YEAR OF DIAGNOSIS)

Medical Problem	Year of Diagnosis/ Details	Medical Problem	Year of Diagnosis/ Details
□ High Blood Pressure		□ Osteoporosis	
□ High Cholesterol		□ Broken Bone	
□ Heart Attack		□ Liver problems/Hepatitis	
□ Stroke		□ Bleeding Problems	
□ Atrial Fibrillation		□ Intestinal Problems	
□ Celiac Disease		□ Thyroid Problem	
□ Cancer		□ Emphysema/COPD	
□ Depression / Anxiety		□ Asthma	
□ Kidney Disease		□ Smoking	
□ Kidney Stones		□ Alcoholism	

Other Problems: _____

_____

_____

SURGICAL HISTORY (list all procedures and operations with year)

Procedure/Surgery	Year	Procedure/Surgery	Year

WOMEN- Menstrual /Pregnancy history

Age of 1st menstruation:_____ Frequency of periods:_____ Length of period: _____ Menopause age: _____

#of Pregnancies:_____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Other female problems _____

If menopausal, using / used Estrogen / Progesterone treatment: Never / Yes. Details: _____

FAMILY HISTORY	**Age**	**Age of Death**	**Cause of Death and/or Medical Problems**
Mother:			
Father:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Brother / Sister:			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			
Child: Girl / boy			

Name:

Date:

SOCIAL HISTORY

Tobacco Use: □ Never □ Quit (Year: ____, After using for_____yrs)

□ Current: # packs/day _____ , # of years _____

Alcohol Use: □ Never □ Quit (Year:_____)

□ Drink _#_____ drinks per day / week / month / year (please circle one)

Drug Use: □ Current □ Never □ Quit (Year:_____) What used?:_____

Have you ever used injectable (i.e. IV) recreational drugs □ Yes □ No

Marital Status: □ Married □ Single □ Separated □ Domestic Partner □ Other: _____

□ Widowed- what year? _____

Sexual Activity: Sexually active? □ Yes □ No □ Not Currently

Current partner is □ Male □ Female

Birth control method (if applicable): _____

Retired? Yes / No. Current or Past Occupation: _____

Highest level of school completed:_____

MEDICATION ALLERGIES / INTOLERANCES: □ NONE

Drug	Reaction	Drug	Reaction

CURRENT MEDICATIONS

Drug	Dose (pill size?)	Dose (amount & frequency)
□ Aspirin	□ 81mg □325 mg	□ One tab once daily □ One tab twice daily _

Current Symptom Review

Rate average energy past week (1=low, 10= high): _____/10

	Symptoms		No Problem	Issue details: circle one N =new, C = chronic. → **Please provide details /changes.**
a)	Fevers/ Sweats	a)		N / C →
b)	Intolerance of cold	b)		N / C →
c)	Intolerance of heat	c)		N / C →
d)	Vision change	d)		N / C →
e)	Sinus or ear symptoms	e)		N / C →
f)	Chest Pains	f)		N / C →
g)	Heart Racing	g)		N / C →
h)	Leg swelling (edema)	h)		N / C →
i)	Shortness of breath	i)		N / C →
j)	Cough	j)		N / C →
k)	Nausea or Vomiting	k)		N / C →
l)	Abdominal Pain	l)		N / C →
m)	Discomfort w/ urination	m)		N / C →
n)	Joint Pains	n)		N / C →
o)	Balance problems / Falls	o)		N / C →
p)	Difficulty with memory	p)		N / C →
q)	Tremor	q)		N / C →
r)	Headaches	r)		N / C →
s)	Skin rash or skin lesions	s)		N / C →
t)	Hair Loss	t)		N / C →
u)	Bleeding / Bruising	u)		N / C →
v)	Allergies	v)		N / C →
w)	Insomnia	w)		N / C →
x)	Anxiety	x)		N / C →
y)	Depression	y)		N / C →
z)	Men:Erectile dysfunction	z)		N / C →

Bowel Movements: Per day _____ OR Per week _____

Urinating at night: none OR # per night _____