



DIABETES QUESTIONNAIRE

Name: _____ Date of Birth: _____

Height: _____ Stated Weight: _____ Recent weight gain or loss? _____

How long have you had diabetes? _____

Family history of diabetes? Y N Relationship? _____

Have you had diabetes education in the past? Y N

Primary care doctor? _____

When was your last dilated eye exam? _____ Dental Visit? _____

Do you have any pain? Y N If yes, where is your pain? _____

Rate your pain on a scale of 1-10 (10 is the worst): _____

Over the past two weeks, have you felt down, depressed or hopeless? Y N

Over the past two weeks, have you felt little interest or pleasure in doing things? Y N

Do you have a blood glucose meter? Y N Name of meter: _____

How many times a day do you test blood sugar and when? _____

Do you have low blood sugar reactions? Y N

If yes, how often? _____ How do you treat it? _____

Do you smoke? Y N Packs per day _____ Chewing tobacco? _____

Have you ever been a smoker? Y N If yes, when did you quit? _____

Do you drink alcohol? Y N If yes, how often? _____

List any food or drug allergies and how you react: _____

Diabetes Medications and Doses: _____

Other medications - include over the counter meds or supplements: _____



Medical history: Circle if you have now or have a history of:

Heart disease High blood pressure Stroke Cancer Mental illness/depression
Infectious disease Kidney disease Sleep Apnea Thyroid issues Eye Disease

Other medical conditions? _____

List any surgeries you had: _____

Do you know your A1c? Y N Result: _____ Date Tested: _____

Are you on a special diet? Circle: Low carb High protein Low sodium
Low fat Low protein Vegetarian Low Potassium

List the foods you typically eat in a day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages you drink: _____

Do you exercise? Y N What kind of exercise do you do? _____

How often? _____ How many minutes? _____

Has your doctor told you to limit exercise in any way? _____

Do you check your feet? Y N

Is there anything else that you would like us to know about you?

List one thing about diabetes that you would like to know before you leave today:

(For Staff: Weight _____ Lbs Kg Blood Pressure _____)