ENDOCRINE SPECIALISTS of Atlanta

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Patient Name________________________________ Date________________

DIABETES QUESTIONNAIRE *(may continue answers on back)*

1. When were you diagnosed as having diabetes, what was your weight then, and what symptoms did you have?
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____

2. What treatment did you receive initially?______________________________

3. Describe any changes in the treatment of your diabetes over the years and reasons for the changes? ______________
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____
____

4. How is your diabetes now being treated (name of oral agent, dose; type of insulin, dose, etc.) ______________
____

5. How do you monitor your sugar (urine testing, blood testing, etc.)? How often do you do this? What results do you get?
____
____

6. Describe the diet you were given for your diabetes (calories, salt restriction, protein restriction, meals, snacks) and how well you are able to follow it.______________________________
____
____

7. Describe any exercise that you do regularly. What level of physical activity is required by your job?______________
____

8. What is your usual daily schedule (include times of diabetic medication, meals, snacks, exercise, work, etc.) How often does this schedule vary significantly? Describe.______________________________
____
____

9. Describe any previous diabetes education that you have had.
____

10. Are you familiar with the following topics?

	Yes	No	Want to know more/Particular questions
Giving insulin	____	____	______________________
Rotating injection sites	____	____	______________________
Mixing insulin	____	____	______________________
Ketones	____	____	______________________
Home glucose monitoring	____	____	______________________
Sick day management	____	____	______________________
Complications of Diabetes	____	____	______________________
Foot Care	____	____	______________________
Glucagon	____	____	______________________
Stress management	____	____	______________________

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11. List and describe any hospitalizations that you have had for diabetes? ______________________________

12. What concerns or feelings do you have regarding your diabetes? ______________________________

13. Have you ever had any of the following problems?

Problem	Now	In past	Explanation
Excessive urination			
Excessive thirst			
Waking up at night to urinate			
Craving for sugar			
Being overweight			
Change in weight			
Low blood sugar			
Headaches			
Nightmares			
Night Sweats			
Tingling in hands/feet			
Numbness in hands/feet			
Burning/pain in hands/feet			
Blurred vision			
Retinal damage			
Retinal surgery			
Floaters/splotches in eyes			
Kidney disease			
Swelling of legs			
High blood pressure			
Heart failure			
Slow healing			
Chronic rash			
Yeast infections			
Babies over 9lbs.			
Sexual problems			
Difficulty urinating			
Nausea after eating			
Diarrhea			

14. If applicable, please list the following:

Your eye doctor ______________________________
Your foot doctor ______________________________
Your kidney doctor ______________________________
Your family doctor ______________________________
Referring physician ______________________________

15. If any member of your family has/had diabetes, please list the following information:

Relative	Age of onset of diabetes	type of treatment	complications