Endocrine & Diabetes Center

QUESTIONAIRE FOR INITIAL EVALUATION OF DIABETES

Name of your referring physician: _____
Name of your primary care physician: _____
Are you self-referred? ❒Yes ❒ No (If yes, how did you find us) _____

Your age: Gender: Marital Status:
Number of children: Occupation: Ethnicity:

REASON FOR EVALUATION/CHIEF COMPLAINT:

_____

HISTORY OF PRESENT ILLNESS:
TYPE OF DIABETES: ❒ Type 1 ❒ Type 2 ❒ Gestational diabetes
ONSET OF DIABETES _____

ASSOCIATED DISORDER:

Obesity	❒ Yes	❒ No
Elevated cholesterol	❒ Yes	❒ No
High Blood pressure	❒ Yes	❒ No
Underactive thyroid	❒ Yes	❒ No
Kidney disease	❒ Yes	❒ No
Neuropathy	❒ Yes	❒ No
Sleep apnea	❒ Yes	❒ No

Other: Please describe: _____

PREVIOUS DIETARY INSTRUCTION ❒ Yes ❒ No If yes, when? _____
PREVIOUS DIABETES EDUCATION ❒ Yes ❒ No If yes, When? _____

WEIGHT HISTORY: ❒ Stable ❒ Lost weight _____ Lbs. ❒ Gained Weight _____ Lbs.

ARE YOU MONITORING YOUR BLOOD SUGAR? ❒ Yes ❒ No
If you monitor your blood sugar, please complete the following:
Range of your blood sugars before breakfast _____mg/dl
Range of your blood sugars 2 hours after meals _____ mg/dl
Average blood glucose over the past 14 days _____mg/dl
What kind of blood glucose meter are you using? _____
How old is your glucose meter? _____
Do you calibrate your meter according to manufacturer instruction? ❒ Yes ❒ No

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EXERCISE HISTORY:
Do you exercise? ❒ Yes ❒ No; If yes what kind_____
Cardio ❒ Yes ❒ No; If yes describe _____

Strength training ❒ Yes ❒ No; If yes, describe_____

BLOOD SUGAR DERANGEMENTS:
Have you had history of hypoglycemia (low blood sugar) ❒ Yes ❒ No; if yes describe
_____
Are you aware of your low blood sugar reaction? ❒ Yes ❒ No; if yes describe
_____
Have you had history of ketoacidosis? ❒ Yes ❒ No; if yes describe

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HISTORY OF INFECTION: Please check if you have had infection of any of the following organs over the past year
❒ Skin ❒ Foot ❒ Dental ❒ Bladder ❒ Kidney

HAVE YOU HAD HISTORY OF ANY OF THE FOLLOWING <u>CHRONIC COMPLICATIONS OF DIABETES?</u>

❒ **EYES:** ❒ Yes ❒ No; check the following if the answer is yes:
❒ History of diabetic retinopathy
❒ Cataract
Date of previous eye examination_____
Name of your ophthalmologist _____

❒ **HEART:** ❒ Yes ❒ No; check the following if the answer is yes:
❒ I have angina.
❒ I have history of coronary artery disease
❒ I have had a myocardial infarction (heart attack)
❒ I have had coronary bypass surgery; Year of surgery _____
❒ I have had coronary angioplasty and stent placement _____-_____
Date of your last EKG _____-_____-_____
Date of your last cardiac evaluation _____
Name of your cardiologist _____-____

❒ **PERIPHERAL NERVES:** ❒ Yes ❒ No; check the following if the answer is yes:
❒ I have been diagnosed to have neuropathy
❒ I have ❒ Numbness ❒ burning feet ❒ Pain in feet at night

❒ **KIDNEY:** ❒ Yes ❒ No; check the following if the answer is yes:
❒ I have history of kidney insufficiency.

❒ I have protein in my urine.

❒ **PERIPHERAL VASCULAR:** ❒ Yes ❒ No; check the following if the answer is yes:
❒ I have pain in my leg with walking; Describe _____
❒ I have circulation problem in my leg
❒ I have had vascular surgery on my leg
❒ I have had angioplasty on my lower extremity arteries
Name of your vascular surgeon ----------

❒ **CEREBROVASCULAR:** ❒ Yes ❒ No; check the following if the answer is yes:
(Circulation to your brain)
❒ I have had stroke. Date_____
❒ I have had transient ischemic attack
❒ I have a history of carotid artery disorder

❒ **PSYCHOLOGICAL DISORDERS:** ❒ Yes ❒ No
Check the following if the answer is yes:
❒ History of anxiety
❒ History of depression
❒ Other psychological disorders. Explain _____

❒ **FEET DISORDERS:** ❒ Yes ❒ No; check the following if the answer is yes:
Describe your foot problems: _____
Name of your podiatrist: _____

❒ **SEXUAL FUNCTION:** ❒ Yes ❒ No; check the following if the answer is yes:
❒ Erectile dysfunction (for men)
❒ Lack of sexual desire

INSULIN THERAPY:
❒ I do not use insulin
❒ I use insulin ❒ pen ❒ vial
What kind of insulin _____
The dose of insulin _____

PAST MEDICAL HISTORY:
Past medical illnesses: Please explain:
_____
_____
_____

Past surgical procedures: Please explain:
_____
_____
_____

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FAMILY HISTORY:
Father: _____
Mother: _____
Sister: _____
Brother: _____
Others: _____

SOCIAL HISTORY:
Alcohol ❒ Yes ❒ No; If yes describe_____
Smoking ❒ Yes ❒ No; If yes describe_____
Recreational drugs ❒ Yes ❒ No; If yes describe_____
Hobbies: _____

ALLERGIES: ❒ I have no known drug allergy.
❒ I am allergic to following drugs: _____

PLEASE BRING THE FOLLOWING REPORTS WITH YOU:

1- **MEDICATIONS:** Complete the medication sheet. Include, name, dose and frequency of drugs you are using.
2- **MOST RECENT LABORATORY TESTS:** Attach a copy of the results
3- **MOST RECENT RADIOLOGICAL STUDIES:** Attach a copy of the results
4- **IMMUNIZATION RECORDS:** Attach a list of immunization dates such as Hepatitis B, influenza, pneumonia, etc.
5- **OTHER HEALTH CARE PROVIDERS:** Please attach name and contact information for all health care providers you see regularly.

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