Endocrine & Diabetes Center

QUESTIONER FOR INITIAL EVALUATION OF DIABETES

PATIENT'S NAME _____ DATE _____
NAME OF YOUR REFERRING PHYSICIAN _____
NAME OF YOUR PRIMARY CARE PHYSICIAN _____

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
Mean 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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301 Maple Avenue West, Suite 120
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Woodbridge, Virginia 22191
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EXERCISE HISTORY:
Do you exercise? ❒ Yes ❒ No; If yes what Kind_____
Cardio ❒ Yes ❒ No; if yes describe _____

Weight lifting; ❒ Yes ❒ No; If yes describe_____

BLOOD SUGAR DERANGEMENTS:
Have you had history of hypoglycemia (low blood sugar) ❒ Yes ❒ No; if yes describe
_____
Are you unaware 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 ❒ No history of infection

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.

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❒ 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_____

❒ **PSYCHOLOGICAL:** ❒ Yes ❒ No; check the following if the answer is yes.
No history of psychological disorder.
❒ History of anxiety
❒ History of depression
❒ Other psychological disorders. Explain _____

❒ **FEET:** ❒ Yes ❒ No; check the following if the answer is yes.
❒ I have foot problem: Explain _____
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 ❒ I uses pen ❒ I use vial
What kind of insulin _____
The dose of insulin _____

PAST MEDICAL HISTORY:
Past medical illnesses:
Explain_____
_____

Past surgical procedures:
Explain_____
_____

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

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

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

MEDICATIONS: Please complete the medication sheet. Include, name, dose and frequency of drug use.

MOST RECENT LABORATORY TESTS: Attach a copy of the results

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