DIABETES INITIAL EVALUATION FORM

Please fill this questionnaire out. If you have problems answering these questions, leave a question mark.
This is a confidential record.

I. PERSONAL INFORMATION

Name: ____

Date of appointment:____/____/________ Reason for visit: _____________________________________

Date of birth: ____/____/________ Age: ____ Sex: ___ M ___ F Marital status: ________________

What is your living arrangement at this time:

Home___ College___ Nursing Home___ Retirement Community___ Assisted Living___ Apartment___

Who lives with you: ____

Your referral physician is: ___________________ Your primary care physician is: ___________________

Do you see other physicians for your health care: _____ Yes _____No If yes, please list below:

____ ____

____ ____

____ ____

Current Occupation: _____________________________ Past Occupation: _____________________________

Highest grade completed: (please check only one)

Some Grade School____ Some High School____ Some College____ Some Postgraduate____
Grade School____ High School____ College Graduate____ Postgraduate Degree____

Tobacco use: Yes____ No____ Year started_________ Year stopped_________

Cigarettes: _____ Cigars: _____ Chewing tobacco: _____ Amount per day_________

Vaping (E-Cigarette): Yes____ No____ Year started_________ Year stopped_________

Alcohol use: Yes____ No____ Type of beverage___________________________ Amount_______________

Recreational drug use: Current____ Past____ Never____ Type____

II. FAMILY HISTORY

Do you know of any blood relative that has or had: (circle and give relationship)

Stroke:	Bleeding tendency:
Bleeding disorder:	Seizures:
Asthma:	Diabetes:
Heart attack:	Thyroid:
Cancer:	Gout:
Pancreatitis:	Kidney disease:
Liver disease:	High blood pressure:

III. PAST HISTORY

Past surgeries or significant injuries

Surgeries or injuries	Date:	Surgeries or injuries	Date:

IV. YOUR MEDICAL HISTORY

Head/Ears/Eyes/Nose/Throat

Eye exam **Yes No**
When: Date: ____/____/______
Dental Exam **Yes No**
When: Date: ____/____/______
Past eye surgery **Yes No**
(including laser treatments)
Sinus problems **Yes No**

Cardiovascular

High blood pressure **Yes No**
Heart murmurs **Yes No**
Valvular disease **Yes No**
Heart attack **Yes No**
Blocked arteries **Yes No**
High cholesterol **Yes No**
Congestive heart failure **Yes No**
Past cardiac stress test **Yes No**
Past EKG **Yes No**

Respiratory

Pneumonia **Yes No**
Asthma **Yes No**
COPD/Emphysema **Yes No**

Skin

Past skin ulcers **Yes No**
Psoriasis **Yes No**
Other skin disease **Yes No**
Type________________________

Genitourinary

Dialysis **Yes No**
Kidney disease **Yes No**
Yeast infection **Yes No**
Protein in urine **Yes No**

Endocrine

Diabetes **Yes No**
Thyroid problems **Yes No**

Gastrointestinal

History of peptic ulcers **Yes No**
Crohns/colitis **Yes No**
Hepatitis/liver problems **Yes No**
Gallstones **Yes No**
Irritable bowel syndrome **Yes No**
Reflux/Gerd **Yes No**
Hiatal hernia **Yes No**

General

Cancer **Yes No**
Type_________________________

Other current or past health issues

____
____
____
____
____
____

Neurological

Seizures **Yes No**
Stroke **Yes No**
Head trauma **Yes No**
Neuropathy **Yes No**

Musculoskeletal

Osteoporosis **Yes No**
Arthritis **Yes No**

Hematological/Lymphatic

Anemia **Yes No**
Past blood transfusion **Yes No**

Psychosocial

Anxiety **Yes No**
Depression **Yes No**
Mental illness **Yes No**
Drug/alcohol abuse **Yes No**
Stress (at home/work) **Yes No**
Abuse
(physical/emotion/sexual) **Yes No**

Pregnancy/Menstrual History

Endometriosis **Yes No**
Ovarian cysts **Yes No**
Are your periods regular **Yes No**
Presently sexual active **Yes No**
Birth control method _________________
Last menstrual period Date ___________
Number of pregnancies _______________
Number of children ______________

V. YOUR CURRENT SYMPTOMS

Head/Ears/Eyes/Nose/Throat

Vision problem	**Yes**	**No**
Sores in mouth	**Yes**	**No**
Sore throat/hoarseness	**Yes**	**No**
Ringing in ears	**Yes**	**No**

Cardiovascular

Rapid or irregular heartbeat	**Yes**	**No**
Abnormal swelling legs/feet	**Yes**	**No**
Chest pain or pressure	**Yes**	**No**

Respiratory

Shortness of breath	**Yes**	**No**
Cough	**Yes**	**No**
Coughing up sputum/blood	**Yes**	**No**

Skin

Skin rashes/itching	**Yes**	**No**
Dry skin	**Yes**	**No**
Sores that don't heal	**Yes**	**No**
Corns or calluses	**Yes**	**No**

Genitourinary

Frequent urination	**Yes**	**No**
Pain with urination	**Yes**	**No**
Blood in urine	**Yes**	**No**
Do you get up at night to urinate	**Yes**	**No**
(if so how often)________		
Erectile dysfunction	**Yes**	**No**

Gastrointestinal

Constipation	**Yes**	**No**
Diarrhea	**Yes**	**No**
Nausea/vomiting	**Yes**	**No**
Heartburn/indigestion	**Yes**	**No**
Blood in stool	**Yes**	**No**
Abdominal pain	**Yes**	**No**

General

Fatigue	**Yes**	**No**
Frequent thirst	**Yes**	**No**
Change in appetite	**Yes**	**No**
Trouble sleeping	**Yes**	**No**
Weight loss (past year)	**Yes**	**No**
How much ____________		
Weight gain (past year)	**Yes**	**No**
How much ____________		

Neurological

Tingling	**Yes**	**No**
Pain or cramps	**Yes**	**No**
Burning pain	**Yes**	**No**
Frequent headaches	**Yes**	**No**

Musculoskeletal

Pain/stiffness in joints	**Yes**	**No**
Backaches	**Yes**	**No**

Hematological/Lymphatic

Enlarged glands	**Yes**	**No**
Excessive bruising	**Yes**	**No**
Abnormal bleeding	**Yes**	**No**

VI. DIABETES HISTORY

Year of your diagnosis with diabetes: ____________

Symptoms at onset of diabetes:

1. ____________________________________
2. ____________________________________
3. ____________________________________

Initial treatment:

1. Hospital …….. ___ Yes ___ No
2. Diet …………. ___ Yes ___ No
3. Oral pills …… ___ Yes ___ No
4. Exercise …….. ___ Yes ___ No
5. Insulin ……… ___ Yes ___ No
6. Education …... ___ Yes ___ No

VII. ALLERGIES

Medication	Reaction

VIII. MEDICATIONS (other than insulin)

PRESENT MEDICATION	DOSE	TIME(s) TAKEN
#1		
#2		
#3		
#4		
#5		
#6		
#7		
#8		
#9		
#10		
#11		
#12		
#13		
#14		
#15		

IX. PAST DIABETES MEDICATION

Past diabetes pills	Dose	Reason for discontinuing
#1.		
#2.		
#3.		
#4.		

X. INSULIN and/or other INJECTION THERAPY

When did you start insulin: ______/______/__________ Do you use insulin vials or pens:__________

Circle type of insulin	Time(s) and amount taken			
	Breakfast	Lunch	Dinner	Bedtime
Humalog/Novolog/Apidra				
Regular or R				
NPH or N				
75/25 - 70/30 – 50/50				
Lantus/Levemir/Toujeo/Tresiba				
Byetta/Symlin/Victoza/Tanzeum/ Trulicity/Bydureon				
Other				

Basal Rate for Insulin Pump

MN	1am	2am	3am	4am	5am	6am	7am	8am	9am	10am	11am
12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm

Which injection sites do you use: ______ arms _____ stomach ______ legs ______ buttocks

Any skin problems at injection site: ___Yes ___No

Do you regularly rotate injection sites: ___Yes ___No

Do you ever give extra insulin: ___Yes ___No

Do you reuse your syringes/needles: ___Yes ___No

Where do you store your insulin: _________________________

How do you dispose of your syringes: _____________________

Who adjusts your insulin: ______________________________

XI. DIABETES EDUCATION

1. Have you made a serious effort to control your diabetes in the past: ____Yes ____No
2. What type of changes are you willing to make to improve your diabetes:
   Diet ____Yes ____No
   Activity ____Yes ____No
   Medications ____Yes ____No
   Other ____

3.Past diabetes education: ____Yes ____No

When: _______________________ Type of education: _______________________________________

XII. GLUCOSE TESTING

Do you test your blood sugar: Yes___ No___ How Often:______________
What brand of meter do you use: ____
How old is your present meter: ____

Do you keep records of your blood sugar test results:	___Yes	___ No	Sometimes_____
Do you test your urine for ketones:	___Yes	___ No	When_______________

What are your typical blood sugar results – Please add to the chart below and bring your blood sugar records

Breakfast		**Lunch**		**Dinner**		**Other**	
Before	**After**	**Before**	**After**	**Before**	**After**	**Bedtime**	**2-3 am**

XIII. HYPOGLYCEMIA

(Also called "Low Blood Sugar or Insulin Reactions")

Frequency of episodes: __ Never __ 0-1 month __ Once a week __ More than 1 per week

Usual severity: ___ Mild (can treat without assistance from other people)
___ Severe (needs help from others)

Usual symptoms: ____

Usual time of day: _______________ Usual treatment: ______________________

Do you have a glucagon kit: ___ Yes ___ No

Do you usually carry diabetes identification: ___ Yes ___ No

Do you wear: ___ dogtags or necklace ____ card ___ bracelet

XIV. CURRENT ACTIVITY AND EXERCISE

Routine daily activity: ____

Type of exercise/activity	Time(s) per week	Time(s) of day	Duration
1.			
2.			
3.			

XV. MEAL PLANNING

Check any of these that apply:

___ I am not on a meal plan
___ I keep away from sweets and sugar
___ I use the exchange system
___ I count calories
___ I "watch" carbohydrates, I do not "count" them
___ I count carbohydrates
___ I limit cholesterol and/or saturated fat
___ Other (please describe:)

How has your weight changed in the last 12 months: ___________________________

Did a Registered Dietitian instruct you on your meal plan: ____ Yes ___ No

How many meals do you eat: _______ What time(s) of the day ______________________________

How many snacks do you eat: ______ What time(s) of the day ______________________________

What sort of problems do you have with your meal plan: ________________________________

Thank you.