DIABETES QUESTIONNAIRE

Date of Appointment: ______________________

Name: _______________________________ Date of Birth: ______________________

When was your diabetes diagnosed? ________________________________

Where you told you were:
Type 1    Type 2    Gestational (diabetes of pregnancy)    Not sure

What symptoms where you having? ________________________________

Have you been told you have any complications of diabetes affecting your

   Eyes (retinopathy)
   Kidneys (proteinuria or nephropathy)
   Nerves or feet (neuropathy)
   Heart (heart attack or blocked heart arteries)
   Slowed digestion (gastroparesis)
   Blocked arteries in your legs (PAD)
   No    Don’t know

Glucose meter
What type of glucose meter do you use? ________________________________

Not sure    I don’t have a meter

Has your meter been tested at the lab to make sure it is accurate?
   Yes    Date: ____________________    No    Not sure

How often have you been asked to test your sugar each day?
   Less than once a day   Once a day   Twice a day
   Before meals   Before meals and bedtime
   Before and after meals   Before meals, bedtime and when I feel low

How well do you do at testing?
   I rarely test as often as instructed.
   Sometimes I miss testing.
   I always test as often as instructed.
   I test more often than instructed.

Diet
What type of diet do you follow?
   No particular diet    Try to watch portions, starches and sweets
   Exchange diet    Strict carbohydrate counting
   “Guestimate” carbohydrate counting    Other diet ________________________________

How well do you do at following this diet?
   Very well    Some days better than others    Fair    Not very well
Exercise

I don’t exercise because ____________________________
I am not able to exercise because ____________________________
I exercise regularly ___________ times a week for _________ minutes.
I exercise sometimes ___________ times a week for _________ minutes.
Type of exercise: ____________________________

I don’t do formal exercise, but I’m very active doing ____________________________

Weight

My weight has been stable lately.
My weight has increased by _______ over the past year.
My weight has decreased by _______ over the past year.
I have been trying to lose weight.
I would like to lose weight.
I am happy with my weight.

Low blood sugar (hypoglycemia)

I have never had a low blood sugar.
I have had mild low blood sugar only occasionally.
I have frequent low blood sugars.
I have had unpredictable or severe low blood sugars.
I have had to go to the ER or hospital for low blood sugar.
When I have a low blood sugar, I feel
jittery               hungry              sweaty            moody         irritable     confused
Other symptom ____________________________ No symptoms at all
When I have a low blood sugar, I treat this with: eating a meal or snack
candy or sweets       fruit juice         soda            glucose tablets
Other treatment: ____________________________

I have and always wear have but don’t always wear don’t have a medical alert bracelet or necklace indicating I am diabetic.

I have a Glucagon Emergency Kit which is in date, and household members have been instructed in how to use this.
I have a Glucagon Emergency Kit, but it may be expired.
I don’t have a Glucagon Emergency Kit/
I don’t know what a Glucagon Emergency Kit is.

Diabetic education

I have never been to any diabetic education classes.
I have been to diabetic education class, but not since ____________________________
I completed diabetic education class series ____________________________
I recently had additional diabetic education regarding:
Diabetic complication screening

Last visit to eye doctor: ________________________________
I have no diabetic eye problems. I don’t know if I have diabetic eye problems.
I have had laser treatments and/or injections for diabetic eye disease.
I see a retina specialist for diabetic eye problems.
I have had a urine test for diabetic kidney trouble, most recently ________________________________
I don’t know if I have had a urine test for diabetic kidney trouble.
I have been told I have diabetic kidney trouble.
I see a kidney specialist.

I have had problems with my feet including:
sores  callouses  ulcers  ingrown toenails  numbness  loss of feeling
fungus in toenails  amputations  other ________________________________
I cut my own toenails without any trouble.
I cut my own toenails but have trouble due to ________________________________
Someone else cuts my toenails: ________________________________

Heart disease risks
I have had heart attack, heart stents or heart bypass surgery.
I have high cholesterol and/or take cholesterol medication.
I have high blood pressure and/or take blood pressure medication.
I have a family history of heart attack in my father or brothers under age 55 or my mother or sisters under age 65.
I am overweight.
I smoke.
I am physically inactive.
I have been told to take 81mg aspirin every day, and I take this.
I have been told to take 81mg aspirin every day, but I don’t take this regularly due to ________________________________
I have not been told to take aspirin.
I have been told NOT to take aspirin due to ________________________________

Dentist
I go to the dentist regularly, every 6 months. My last appointment was ________________________________
I go to the dentist yearly. My last appointment was ________________________________
I have dentures and do not go to the dentist.
I do not go to the dentist regularly because ________________________________

If you do not use insulin, you do not need to fill out the rest of this form.
**Insulin**

When did you start using insulin? At time diabetes was diagnosed __________ (year)

Don’t remember

I use vial and syringe insulin pen pump (please skip to pump section below)

My insulin shots are given by: me my spouse my partner my parents a family member ____________ school nurse or aide other ________________

I always remember to take my insulin.

I rarely forget to take my insulin.

I frequently forget to take my insulin.

I am most likely to forget to take a shot at lunchtime bedtime snack time other time_____

Shots are given in the following locations: abdomen arms hip area thigh other ________________

I have problems with bruising at the places I give my shots.

I have problems with lumps, firm areas or thickening of the tissue at the places I give my shots.

I have no problems at the places I give my shots.

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**Insulin pump**

I first started to use a pump ____________________________

Make and model of current pump: ____________________________

Date purchased: _______________________________________

My carbohydrate ratios are:

____ unit/____ gram of carb from ______ to ______ (time)

____ unit/____ gram of carb from ______ to ______ (time)

____ unit/____ gram of carb from ______ to ______ (time)

____ unit/____ gram of carb from ______ to ______ (time)

My insulin sensitivity/correction factor(s):

____ unit for every ______ mg/dl glucose from ______ to ______ (time)

____ unit for every ______ mg/dl glucose from ______ to ______ (time)

____ unit for every ______ mg/dl glucose from ______ to ______ (time)

____ unit for every ______ mg/dl glucose from ______ to ______ (time)

I correct to a blood sugar of ____________________________

Active insulin time is: ____________________________ I don’t use this or don’t know what it is.

Insulin infusion set type: ____________________________

I change my set every 2 days 3 days ______ days because ____________________________

Basal rates:

Midnight until _________, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

_________ until _______, rate is _________ unit/h

24h basal insulin total: ____________________________

Total daily insulin dose range: ____________________________