Diabetes Questionnaire

Patient name: _____ Date of Birth: _____

Self- referral or referred by: _____

Prior endocrinologist (if any): _____

Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

1) **Circle one:** Pre-diabetes / Type 1 diabetes / Type 2 diabetes
2) **Date diabetes was diagnosed:** _____
3) **How was it diagnosed (routine labs, symptoms, hospitalization)?** _____
4) **Medications initially started for diabetes at diagnosis:**
   _____
5) **Name and doses of medications you are currently taking for diabetes:**
   _____
   _____
6) **Do you take medications as prescribed?** ____Yes or ____no
7) **Circle any other diabetes medications you have tried and that is not listed above:**

   Metformin____ Glipizide____ Glimepiride____ Glyburide____

   Pioglitazone____ Rosiglitazone____ Repaglinide____ Acarbose____ Pramlinitide____

   Victoza (Liraglutide)____ Trulicity (Dulaglutide)____ Ozempic (Semaglutide)____
   Tanzeum (Albiglutide)____ Byetta (Exenatide)____ Bydureon (Exenatide) ____

   Tradjenta (Linagliptin)____ Januvia (Sitagliptin)____ Onglyza (Saxagliptin) ____

   Invokana (Canagliflozin)____ Farxiga (Dapagliflozin)____ Jardiance (Empagliflozin) ____

   Glyxambi (Empagliflozin/Linagliptin)____ Synjardy (Empagliflozin/Metformin)____
   Xigduo XR (Dapagliflozin/Metformin) ____

   Humalog____ Novolog____ Lantus____ Levemir____ Regular insulin____ NPH____
   Toujeo____ Tresiba____ 70/30____ U-500____

   Other medications not listed above: _____

   I have not used any other diabetes medications____

8) **How many times a day do you check your glucose (Circle one)?**
   0 ____ 1 ____ 2 ____ 3____ 4____ 5____ or more____

9) In the last week what was your lowest glucose? _____
10) In the last week what was your highest glucose? _____

11) How many times a month do you have glucose levels less than 70?

0 ____ 1 ____ 2 ____ 3____ 4____ 5____ or more____

12) What did you eat and drink yesterday?

Breakfast	_____
Lunch	_____
Dinner	_____
Snack	_____

Exercise:

If yes, how many times a week and for how long? _____

If no, why? _____

13) Past medical history: Select if you have had or have any of these

Heart attack ____ Stroke ____ Peripheral arterial disease ____ Kidney disease ____ Thyroid dysfunction____ Medullary thyroid cancer____ Pancreatitis____ Diabetic ketoacidosis____ Urinary tract infections____ Toe or other limb amputations____ None of these____

	Yes	**No**	**Details**
Have you had recent labs for hemoglobin A1C?	____	____	**Date:** ____
Do you take a cholesterol lowering medication?	____	____	**Name:** ____
Have you had a dilated diabetic eye exam?	____	____	**Date:** ____
Do you have diabetic retinopathy (damage to your eye)?	____	____	____
Do you have diabetic neuropathy (nerve damage)?	____	____	____
Have you had the pneumonia vaccine?	____	____	**Date:** ____

Symptoms (Circle if you have had any in the last 1 month):

Fatigue ____ fever ____ weight gain ____ weight loss ____

Vision changes ____ trouble swallowing ____

Chest pain____ shortness of breath ____ leg swelling ____ palpitations ____

Diarrhea ____ constipation____ decreased appetite____ abdominal pain____

Increased thirst ____ frequent urination____ night time urination____

Anxiety ____ depression ____

Intolerance to cold ____ intolerance to heat____

Numbness or tingling in your hands or feet____ lesions or sores on your feet____

Pain in your hands____ pain in your feet ____ joint pain____

None of the above____