Palm Beach Diabetes and Endocrine Specialists, P.A.

Diabetes Questionnaire

Your Name Last:_____ First: _____

Your Age: _____Sex:_____Date of Birth: _____Telephone: _____

- Have you seen a nutritionist? ☐ Yes ☐ No
- Have you ever been to a Diabetes Education Class? ☐ Yes ☐ No
- Insulin users, please complete by entering the number of units you are administering in the appropriate box.

TYPE	A.M.	LUNCH	DINNER	BED
NPH or Lente				
Regular or Humalog				
70/30				
Ultralente				

- Check any of the following which apply:

☐ angina
☐ heart attack
☐ stroke
☐ Bell's Palsy
☐ carpal tunnel syndrome
☐ amputation
☐ dialysis
☐ kidney transplant

If yes to any of the above, supply details:

_____

_____

- Are you experiencing any of the following?

fatigue	☐ Yes	☐ No	difficulty with erections	☐ Yes	☐ No
blurry vision	☐ Yes	☐ No	vaginal itch	☐ Yes	☐ No
frequent urination	☐ Yes	☐ No	constipation	☐ Yes	☐ No
excessive thirst	☐ Yes	☐ No	shortness of breath	☐ Yes	☐ No
pain in the calves when walking	☐ Yes	☐ No	chest pain	☐ Yes	☐ No
tingling in the hands or toes	☐ Yes	☐ No	dry skin	☐ Yes	☐ No
excessive hunger	☐ Yes	☐ No	depression	☐ Yes	☐ No

- Are you experiencing hypoglycemic episodes (morning, afternoon, evening, early a.m.)

_____

- List any family members with diabetes: _____
- List any medication allergies: _____
- Have you had any pregnancies? When was the last delivery? _____
- Are you post-menopausal? If so, how many years ago was your last menses? _____
- Would you like information regarding our Diabetes Research Program? _____
- What is the number one question on your mind regarding diabetes?

_____

_____

◆ How long have you had diabetes? _____

◆ If you are using insulin, how long have you been on it? _____

◆ What is your present weight? _____

◆ Approximately, how much did you weigh last year?_____ Five years ago? _____

◆ How many days do you exercise weekly? ☐ almost daily ☐ 3-5 ☐ 1-2 ☐ almost never

◆ On a scale from 1 to 5 (5 being the most strict), how strictly do you observe your diet? _____

◆ Do you monitor your blood glucose at home? ☐ Yes ☐ No

◆ If yes, how many times daily? _____

◆ If you do home glucose monitoring please fill in the grid below:

	A.M.	LUNCH	DINNER	BED
Low				
High				
Average				

◆ Do you know your latest glychoemoglobin or A1c result? _____

◆ If so, what was the value and indicate whether it was A1c: _____

◆ List all operations (of any sort) and year: _____

_____

_____

◆ Have you ever been told you have any of these diabetic complications:

Kidney disease ☐ Yes ☐ No Eye disease ☐ Yes ☐ No

Nerve damage ☐ Yes ☐ No Protein in the urine ☐ Yes ☐ No

Decreased blood flow to the legs or feet ☐ Yes ☐ No

◆ If yes to any of the above, supply details:_____

_____