Name _____ Date _____ Chart # _____

HISTORY FORM FOR PATIENTS WITH KNOWN DIABETES

1) Date of diagnosis. _____

2) A) Do you follow a diet? Yes _____ No _____

B) Do you take snacks regularly? Yes _____ No _____ Middle of the morning? Yes _____ No _____ Afternoon, Yes _____ * No _____ Bedtime? Yes _____ No _____

C) How many calories are in your diet? _____

3) A) Do you monitor your blood glucose at home? Yes _____ No _____

B) What Glucometer do you use? _____

C) How often do you check your blood sugar? _____
Before which of the meals? Breakfast _____ Lunch _____
Supper _____ Bedtime _____ (Check the appropriate one)

D) What are the results? Before breakfast _____ Before lunch _____
Before Supper _____ Before bedtime _____

4) A) Are you having low sugar spells? Yes _____ No _____
B) At what time do they occur? _____
C) How often do they occur? _____/week _____/month

5) Have you lost consciousness from low sugar? Yes _____ No _____
When? _____

6) Have you ever experienced ketoacidosis? Yes _____ No _____

7) A) Is there a family history of diabetes mellitus? Yes _____ No _____
B) If so, who? _____

8) A)Do you take insulin? Yes _____ No _____
B) If yes, what kind of insulin? _____
C) What time of day do you take your insulin? _____
D) How much insulin do you take at each injection? _____

9) Have you ever, or do you presently take diabetes pills? Yes _____ No _____
If yes, what is the name? _____

10) Do you have burning pain or numbness in your hands or feet? Yes _____ No _____
If yes, for how long? _____

11) Have you experienced any recent weight loss? Yes _____ No _____
If yes, how much? _____

12) Have your experienced any weight gain? Yes _____ No _____
If yes, how much? _____

13) What has been your maximum weight and when? _____

14) Do you wake up at night to urinate? Yes _____ No _____
If yes, how many times? _____

15) Do you find yourself excessively thirsty and having to drink several glasses of liquid a day?
Yes _____ No _____

16) Are you experiencing any problem with sexual relations? Yes _____ No _____

17) Do you have any trouble with your eyes? Yes _____ No _____
If yes, explain _____

18) For Women: Do you have recurrent yeast vaginal infections? Yes _____ No _____