DIABETIC HEALTH
AND WELLNESS

DIABETIC CONSULTATION FORM

QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

1. How old are you? _____
2. Are you ☐ **Type 1 Diabetic,** ☐ **Type 2 Diabetic,** ☐ **Pre-Diabetic, or** ☐ **Non-Diabetic**?
3. When were you diagnosed with diabetes? _____
4. How were you diagnosed: ☐ **symptoms presented** ☐ **routine exam** ☐ **after or during hospitalization**?
5. Do you have a metabolic disorder? ☐ **Yes** ☐ **No**

   If yes, what type?_____
6. Where could this disorder come from: family history, being overweight, or an unknown cause? _____
7. How much did you weigh at the time of your diagnosis? _____
8. How much do you currently weigh? _____
9. Please check the following symptoms you are currently experiencing:

- ☐ Uncontrolled blood sugars
- ☐ Retinopathy (loss of vision)
- ☐ Neuropathy (numbness and/or tingling in extremities)
- ☐ Erectile Dysfunction
- ☐ Hyperlipidemia (blood has too many lipids or fats)
- ☐ Gastroparesis (delayed stomach emptying)
- ☐ Hypertension (high blood pressure)
- ☐ Nephropathy (loss of kidney function)
- ☐ Impaired Skin Integrity (wounds, delayed wound healing)
- ☐ Urinary Frequency
- ☐ Polyphagia (excessive eating)
- ☐ Polydipsia (excessive thirst)
- ☐ Ulcers
- ☐ Weight Loss
- ☐ Hypoglycemia (low blood sugars)

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10. What was your last Hgb A1c? _____
11. How many meals do you eat per day? _____
12. Do you check your blood sugars at home? ☐ **Yes** ☐ **No**
13. If so, how many times a day do you check your blood sugars? _____
14. What is the range of your fasting blood sugar? _____
15. What is the range of your blood sugar numbers 2 hours after eating a large carbohydrate meal? _____
16. What is the range of your blood sugars at bedtime? _____
17. How often do your blood sugars go below 80mg/dlL? ☐ **Always** ☐ **Sometimes** ☐ **Never?**

18. How has your diabetes diagnosis been managed?
Please select all that apply:

- ☐ 24 hr Urine Collection
- ☐ Retina Exam
- ☐ Vascular Testing
- ☐ Diabetes Education
- ☐ Dietician Visits
- ☐ Nerve Testing

19. What are the current ways of managing your diabetes diagnosis? Please select all that apply:

- ☐ Diet Therapy
- ☐ Exercise
- ☐ Monitoring Blood Sugars
- ☐ Oral Agents

20. Have you been on insulin in the past? _____
21. If so, how long? _____
22. How effective are your diabetic medications at controlling your blood sugars?
Please select:
☐ **Poor** ☐ **Good** ☐ **Excellent**

23. What are your current diabetic meds?
Please list the type of medication, the amount you take, and how often.

24. Do you have sensation in your hands and feet? Please select: ☐ **Full Sensation** ☐ **Loss of Sensation**
25. Have you been to a podiatrist in the past? ☐ **Yes** ☐ **No**
26. If so, when was your last visit with the podiatrist?
27. Do you have any amputations? ☐ **Yes** ☐ **No**

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28. If you have amputations, what are they?

29. Do you cut your own toenails? ☐ **Yes** ☐ **No**

30. Do you have kidney disease? ☐ **Yes** ☐ **No**

31. If yes, when were you diagnosed?

32. Do you have problems with your eyes?

☐ **Yes** ☐ **No**

33. Do you wear glasses for correction?

☐ **Yes** ☐ **No**

34. When was your last eye exam?

35. How would you describe your memory?

36. How would you describe your mood?

37. Do you exercise? ☐ **Yes** ☐ **No**

38. If yes, how often and what do you do?

39. How would you describe your muscle strength? ☐ **Weak** ☐ **Average** ☐ **Strong**

40. How would you describe your endurance? ☐ **Weak** ☐ **Average** ☐ **Strong**

41. Have you been in the ER or hospitalized for a condition related to diabetes in the past 12 months?

☐ **Yes** ☐ **No**

42. Has your cholesterol been checked in the last 12 months? ☐ **Yes** ☐ **No**

43. Have your urine proteins been checked in the last 12 months? ☐ **Yes** ☐ **No**

44. Who is your Primary Care Doctor? _____

45. When was your last visit with your primary care doctor? _____

46. Are you experiencing any pain today? ☐ **Yes** ☐ **No**

If yes, what would you rate the pain 1-10, 10 being the worst? _____

47. Have you had recent blood work done? ☐ **Yes** ☐ **No** If yes, how long ago? _____

Do you have copies of the results? ☐ **Yes** ☐ **No**