Palm Beach Diabetes & Endocrine Specialists, P.A.
Diabetes Questionnaire

Last Name:_____ First Name:_____

Your Age: _____ Sex: _____ Date of Birth:_____ Phone: _____

Have you seen a nutritionist? ☐ Yes ☐ No

Have you ever attended a Diabetes Education Class? ☐ Yes ☐ No

Insulin users: Please complete the information below by entering the number of units you are administering into the appropriate box.

TYPE	UPON RISING	LUNCH	DINNER	BEFORE BED
NPH or Lente				
Regular or Humalog				
70/30				
Ultralente				

Check any of the following which apply to you:

	Angina		Carpal Tunnel Syndrome
	Heart Attack		Amputation
	Stroke		Dialysis
	Bell's Palsy		Kidney Transplant

If you placed a check in any of the boxes above, please explain:

_____

_____

Are you experiencing any of the following?

	Y	N		Y	N
Fatigue			Difficulty with Erections		
Blurred Vision			Vaginal Itch		
Frequent Urination			Constipation		
Excessive Thirst			Shortness of Breath		
Calf Pain When Walking			Chest Pain		
Tingling in the Hands or Toes			Dry Skin		
Excessive Hunger			Depression		
Loss of appetite					

Are you experiencing hypoglycemic episodes? ☐ Yes ☐ No When?_____

List any family members with diabetes:_____

List medication allergies:_____

Have you had any pregnancies? ☐ Yes ☐ No When was the last one?_____

Are you post-menopausal? ☐ Yes ☐ No Date of last menses?_____

Would you like information regarding our Diabetes Research Program? ☐ Yes ☐ No

What is the most important question you have regarding diabetes? _____

_____

How long have you had diabetes? _____ If using insulin, for how long? _____

Regarding your weight:

Present weight _____ What did you weigh last year?_____ Five years ago?_____

How many days a week do you exercise? ☐ Almost daily ☐ 1-2 ☐ 3-5 ☐ almost never

On a 1-5 scale (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 per day? _____

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

	UPON RISING	LUNCH	DINNER	BEFORE BED
LOW				
HIGH				
AVERAGE				

Do you know your latest glychoemoglobin or A1c result? ☐ Yes ☐ No

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

Have you ever been told you have any of these diabetic complications?

	Y	N		Y	N
Kidney disease?			Decreased blood flow to legs or feet?		
Nerve damage?			Protein in the urine?		
Eye disease?					

If yes, to any of these complications, please supply details: _____

_____

THANK YOU FOR FULLY COMPLETING THIS FORM!