

**New West Physicians Diabetes and Nutrition Center**

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**New Patient Diabetes Questionnaire**

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Occupation: \_\_\_\_\_

- Please use my e-mail address to sign me up for the quarterly New West Physicians newsletter.
  - Please use my e-mail address to add me to the Diabetes and Nutrition Center Event Contact List.
  - Please use my home address to add me to the Diabetes and Nutrition Event Contact List
- How tall are you? \_\_\_\_\_ How much do you weigh? \_\_\_\_\_

Are you happy with your weight? Yes No If no, what is your goal weight?  
\_\_\_\_\_

Are you on a special diet? Yes No If yes, what type? \_\_\_\_\_

How often do you exercise?  Never  \_\_\_ Times per Week  \_\_\_ Times per Month

What type of exercise do you do? \_\_\_\_\_/for how many minutes? \_\_\_\_\_

Do you Smoke or Chew Tobacco? Yes No If yes, when did you start? \_\_\_\_\_

How much per day? \_\_\_\_\_ On a scale of 1 to 10, how ready are you to quit?:  
Not at all: 1 2 3 4 5 6 7 8 9 10 :Very Much

Are you exposed to second hand smoke? Yes No

How often do you drink alcohol?  
 Never  \_\_\_ Times per Week  \_\_\_ Times per Month  \_\_\_ Times per Year

Do you have a support person? (Someone to help you in an emergency.) Yes No

Have you been to the Emergency Room or Hospital with any Diabetes-Related problems in the last 5 years?  
Yes No If yes, what happened? \_\_\_\_\_

Over the past two weeks have you felt down, depressed, and or hopeless? Yes No

Over the past two weeks have you felt little interest or pleasure in doing things? Yes No

Do you check your blood glucose at home? Yes No

What times of day do you test:  
Morning \_\_\_\_\_ Noon \_\_\_\_\_ Night \_\_\_\_\_ Other \_\_\_\_\_

What kind of blood glucose meter do you have?

- AccuChek Advantage AccuChek Aviva AccuChek Compact
- Bayer Contour One Touch Basic/Profile One Touch Ultra/Ultra Smart
- Precision Xtra Therasense Freestyle Therasense Flash
- Other \_\_\_\_\_ No Meter

Do you have any complications from diabetes? (Check all that apply)

- Eye problems Delayed digestion or stomach problems
- Protein in your urine or kidney damage Pain or tingling in hands/feet, or nerve damage
- Sexual dysfunction None / I don't know

**Treatments**

**Insulin Dosage (check all that apply)**

Insulin	Dose	Times Taken

<input type="checkbox"/> Lantus or Levemir		
<input type="checkbox"/> Humalog or Novolog		
<input type="checkbox"/> Apidra Insulin		
<input type="checkbox"/> Regular Insulin		
<input type="checkbox"/> NPH Insulin		
<input type="checkbox"/> Insulin Pump (see below)		
<input type="checkbox"/> Symlin Injection (Pramlintide)		
<input type="checkbox"/> Byetta Injection (Exenatide)		

Do you take Oral Medication for you Diabetes? Yes No If yes, please fill in the table below.

**Diabetes Medications List: (check all that apply)**

Medication	Dose	Times per Day
<input type="checkbox"/> Glyburide (Diabeta, Glynase) or Glipizide (Glucotrol)		
<input type="checkbox"/> Metformin (Glucophage)		
<input type="checkbox"/> Rosiglitazone (Avandia) or Pioglitazone (Actos)		
<input type="checkbox"/> Sitagliptin (Januvia)		
<input type="checkbox"/> Other (please indicate)		

**Non-Diabetes Medications List.**

**Please include over-the-counter, vitamins, herbs, and supplements as well as prescriptions.**

If you cannot fit all your medications on this table, please list them on a separate sheet of paper.

Medication	Dose	Times per Day	Reason
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			
<input type="checkbox"/>			