

11. My overall Blood glucose readings average: 80–120 120–140 140–160
 160–180 180–200 200–240 240–280 280–320 >320
12. Most Frequent time of Low Blood Sugar: Morning MidMorning Noon
 MidAfternoon Evening Bedtime Middle of Night
13. My meal or snack plan is: None ADA Weight Watchers Low Carbohydrates
14. Do you skip meals? Yes No
15. My Exercise Plan is mostly: Walking Running Swimming Lifts Weights
16. Frequency of Exercise Per Week: 1–2 times 2–3 times 3–4 times >4 times
17. Have you seen an eye doctor in the last year? Yes No
18. Have you seen a dietitian in the last year? Yes No
19. Do you Smoke? Yes No
20. Do you wear a medic alert bracelet or necklace? Yes No
21. Do you have a Glucagon Kit at home? Yes No
22. Do you carry and have in car sugar-raising “stuff”? Yes No

For other chronic medications or therapy, please list them in this chart:
 (Include vitamins, herbs, aspirin products, estrogens & contraceptives)

| | MEDICATION | DOSE | HOW OFTEN? |
|-----|------------|------|------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |

What is the biggest area that you feel needs to be worked on or improved?

PLEASE GIVE THIS SHEET TO THE FRONT DESK BEFORE YOU ARE CALLED BACK TO A ROOM. THE FRONT DESK WILL RETURN A COPY TO YOU, PLEASE GIVE THIS COPY TO THE NURSE.

PLEASE LET THE NURSE KNOW IF YOU NEED YOUR PRESCRIPTIONS REFILLED. We suggest you keep a list of medications with doses and frequency in your wallet or purse. Thanks again very much!