

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Visit Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Before you come in for initial visit, you can PRINT this form and fill it out at home. Find the picture of a printer in the upper left corner of this form and click on it to print. Thanks!**

Your approximate date of diagnosis: \_\_\_\_\_

History of diagnosis (include where, by whom, follow-up, blood glucoses and symptoms):

● **Diabetes monitoring:**

- a. checking:  blood sugar  urine ketones  nothing
- b. frequency: times per day: \_\_\_\_\_ days per week:  everyday  other: \_\_\_\_\_
- c. brand of testing device(s): \_\_\_\_\_
- d. average blood sugar (if known):  
 AM: \_\_\_\_\_ Lunch: \_\_\_\_\_ Supper: \_\_\_\_\_ Bedtime: \_\_\_\_\_ Other: \_\_\_\_\_

Last Hemoglobin A1c: \_\_\_\_\_ . Unknown:

Is there a history of:

- > Eye damage from diabetes:  Yes  No
- > Diabetic nerve damage to feet/hands:  Yes  No
- > Sexual problems:  Yes  No
- > High blood pressure:  Yes  No
- > Heart attack, stroke or other heart problems:  Yes  No
- > Diabetic kidney problems or protein in urine:  Yes  No
- > High cholesterol / triglycerides:  Yes  No
- > Tobacco use:  Currently Yes  Past Yes  Never Describe: \_\_\_\_\_

● **Current symptoms:**  None

- weight loss
- weight gain
- change in appetite
- increased urination
- night time urination
- increased water drinking
- dizziness
- tiredness
- blurred vision
- skin infections
- leg cramps/pain
- burning feet, other
- itchy skin
- nausea or fullness
- belly bloating
- impotence/sexual problems
- vaginal infections
- bladder infections
- other: \_\_\_\_\_

● **Current diabetes plan includes:**

diabetes pills: (list CURRENT types/doses/times per day) \_\_\_\_\_

insulin regimen: a. list types/doses & times of doses: \_\_\_\_\_

b. do you use:  insulin vial  insulin pen (brand):

c. rotation of injections to:  stomach  arm  thigh  hip  other: \_\_\_\_\_

if insulin pump: a. brand/model of pump: \_\_\_\_\_ basal rate(s): \_\_\_\_\_

b. how much bolus insulin do you give pre-meals & how do you calculate bolus adjustments:

nutritional / diet plan:  carbohydrate counting.  ADA calories: \_\_\_\_\_  low fat/cholesterol.  other: \_\_\_\_\_

exercise plan: type: \_\_\_\_\_ frequency: \_\_\_\_\_ How many minutes each time? \_\_\_\_\_

Do you take an aspirin daily?  Yes  No. Dose: \_\_\_\_\_ mg.

Do you wear a medic-alert bracelet/necklace?  Yes  No.  Do you have glucagon at home?  Yes  No.

Are you an ADA/JDF member?  Yes  No.  Are there sugar raising food/supplies in the car?  Yes  No.

Have you seen an eye doctor in the last year?  Yes  No.  Do you perform routine foot care?  Yes  No.

● **Metabolic imbalance:**

a. Diabetic Ketoacidosis: \_\_\_\_\_  none

b. Coma from high or low blood sugar: \_\_\_\_\_  none

c. Low blood sugars: frequency: \_\_\_\_\_ most likely times of the day: \_\_\_\_\_  none

Explain please: \_\_\_\_\_