Name: _____

- DIABETES MEDICAL HISTORY FORM –

- Initial Diagnosis and Treatment -

What type of diabetes do you have:

☐ Type 1 ☐ Type 2 ☐ Gestational

☐ Uncertain

What year were you diagnosed with diabetes?

_____

How were you initially treated for diabetes?

☐ Diet/exercise ☐ Insulin ☐ Pills

- Family History –

Do you have family members with diabetes?

☐ Yes ☐ No Type 1 List:

_____

☐ Yes ☐ No Type 2 List:

_____

- Diabetes Self-Management Education -

☐ Yes ☐ No Did you receive diabetes education when you were first diagnosed?

☐ Yes ☐ No Do you see a diabetes educator at least once each year?

Most recent visit (date):_____

- Medical Nutrition Therapy -

☐ Yes ☐ No Did you receive dietary education when you were first diagnosed?

☐ Yes ☐ No Do you see a dietitian at least once each year?

Most recent visit (date): _____

- Do Not Write In This Column -

- DIABETES MEDICAL HISTORY FORM –

- Current Meal Plan -

- Do Not Write In This Column -

☐ Yes ☐ No Do you following a meal plan?

Do you measure or restrict:

☐ Calories ☐Salt ☐Protein ☐ Fat/cholesterol

☐ Yes ☐ No Do you counts carbohydrates?

☐ Yes ☐ No Do you use a carbohydrate ratio to determine your mealtime insulin dose?

☐ Yes ☐ No Do you avoid concentrated sources of sugars?

How many grams of carbohydrate do you eat at each of these times:

_____ grams Breakfast

_____ grams morning snack

_____ grams Lunch

_____ grams afternoon snack

_____ grams Dinner

_____ grams bedtime snack

What time do you eat:

_____ Breakfast

_____ morning snack

_____ Lunch

_____ afternoon snack

_____ Dinner

_____ bedtime snack

- DIABETES MEDICAL HISTORY FORM –

- Physical Activity -

- Do Not Write In This Column -

☐ Yes ☐ No Do you exercise regularly?

How many days do you exercise each week?

_____

☐ Yes ☐ No Do you have any physical conditions that limit your ability to exercise.

If yes, what are they?

_____

What type of activities do you do?

_____

How long do you exercise?

_____

When you exercise:

☐ Yes ☐ No Do you decrease your dose of insulin or your oral diabetes medication?

☐ Yes ☐ No Do you eat additional carbohydrate before or during exercise?

- Oral Medications -

List oral medicines you have used to treat your diabetes:

☐ Yes ☐ No Are you having side effects from your diabetes medications?

If yes, please describe:

_____

_____

- DIABETES MEDICAL HISTORY FORM –

- Insulin Therapy: What is your insulin regimen? -

Morning: _____
Noon: _____
Evening: _____
Bedtime: _____

What is your Carbohydrate Ratio?

_____

What is your Correction Factor?

_____

Insulin Pump Basal Rates:

_____
_____
_____
_____

Total number of units of all types of insulin used each day: _____

- Injection Sites -

Where do you inject your insulin?
☐ Abdomen ☐ Arms ☐ Legs ☐ Buttocks

Are there skin problems where you inject?
☐ Callusing/Thickening ☐ Excessive bruising
Other:

_____
_____

- Do Not Write In This Column -

- DIABETES MEDICAL HISTORY FORM –

- Home Blood Glucose Monitoring -

Blood Glucose Meter Used:

_____

How many days each week do you test your blood glucose? _____

How many times each day do you test your blood glucose? _____

☐ Yes ☐ No Do you test more often when you are ill?

☐ Yes ☐ No Do you keep a written record of your blood glucose values?

- Glucose Value Ranges –

Please record your average glucose ranges (e.g. 90-140) for each of the times you test.

Breakfast: _____

after breakfast: _____

Lunch: _____

after lunch: _____

Supper: _____

after supper: _____

Bedtime: _____

Overnight: _____

- Hyperglycemia – High Blood Glucose

☐ Yes ☐ No Are you experiencing symptoms of high blood sugars?

Indicate the symptoms you experience:

☐ Thirst ☐ Frequent urination ☐ Blurred vision

☐ Yes ☐ No Were you ever admitted to the hospital for diabetic ketoacidosis or very high glucose levels?

If yes, when and why?

_____

- Do Not Write In This Column -

- DIABETES MEDICAL HISTORY FORM –

- Hypoglycemia – Low Glucose Reactions

☐ Yes ☐ No Do you have low blood glucose reactions?

How often do you have reactions?

_____

What are your glucose values during the reactions? _____

What time of day do your reactions usually occur?

_____

What is/are the reasons for your hypoglycemic reactions?

☐ Yes ☐ No Missed or delayed meals

☐ Yes ☐ No Increased physical activity

☐ Yes ☐ No Change in insulin dose or oral diabetes medicines

Indicate which of the following you experience when your blood glucose is low:

☐ Shaking ☐ Sweating

☐ Heart racing or skipping

☐ Feeling nervous or anxious

What do you eat to treat a low glucose reaction? (Item and amount eaten e.g. 4 oz orange juice)

_____

☐ Yes ☐ No Do you carry a rapid-acting source of glucose in case you go low?

If yes, what do you carry?

_____

- Hypoglycemia Unawareness -

Do you experience any of the following when your blood glucose is low?

☐ Confusion ☐ Fatigue ☐ Irritability

☐ Seizures ☐ Loss of consciousness

Have you ever:

☐ Yes ☐ No Required assistance of others? (if yes, describe)

_____

☐ Yes ☐ No Required treatment in the emergency room? (If yes, describe)

_____

_____

☐ Yes ☐ No Required glucagon therapy

_____

_____

Please list persons trained to give glucagon: (family members, coworkers, others)

_____

_____

- DIABETES MEDICAL HISTORY FORM –

- Retinopathy - Eye Disease

- Do Not Write In This Column -

Who is your eye doctor?

_____

How often do you have a dilated eye exam:

_____

When was your last eye exam?

_____

Are you having problems with:

☐ Yes ☐ No Double vision

☐ Yes ☐ No Loss of vision

☐ Yes ☐ No Distorted vision

Have you been diagnosed with:

☐ Yes ☐ No Nonproliferative retinopathy

☐ Yes ☐ No Proliferative retinopathy

☐ Yes ☐ No Macular edema

☐ Yes ☐ No Macular degeneration

☐ Yes ☐ No Cataracts

☐ Yes ☐ No Glaucoma

Have you had the following treatments?

☐ Yes ☐ No Laser treatment

☐ Yes ☐ No Vitrectomy

☐ Yes ☐ No Cataract surgery

☐ Yes ☐ No Glaucoma surgery

- Nephropathy – Kidney Disease

Have you been diagnosed or had trouble with:

☐ Yes ☐ No Hypertension

☐ Yes ☐ No Proteinuria (protein in your urine)

☐ Yes ☐ No Swelling in your feet and ankles

☐ Yes ☐ No Abnormal blood tests of your kidney function (BUN, Creatinine)

- DIABETES MEDICAL HISTORY FORM –

- Neuropathy – Nerve Damage

- Do Not Write In This Column -

Do you have any of these problems in your **hands and arms:**

☐ Yes ☐ No Pain

☐ Yes ☐ No Numbness

☐ Yes ☐ No Burning or stabbing sensations

☐ Yes ☐ No Tingling sensation

Do you have any of these problems in your **feet and legs:**

☐ Yes ☐ No Pain

☐ Yes ☐ No Numbness

☐ Yes ☐ No Burning or stabbing sensations

☐ Yes ☐ No Tingling sensation

Have you had problems with:

☐ Yes ☐ No Dizziness when going from sitting to standing

☐ Yes ☐ No Nausea and vomiting undigested food after you eat

☐ Yes ☐ No Constipation - chronic

☐ Yes ☐ No Diarrhea - chronic

☐ Yes ☐ No Difficulties having erections or intercourse

- DIABETES MEDICAL HISTORY FORM –

- Foot Problems -

- Do Not Write In This Column -

☐ Yes ☐ No Do you see a foot doctor on a regular basis?

If yes, what problems do you have?

_____

_____

Name of your foot doctor:

_____

☐ Yes ☐ No Have you had foot surgery?

_____

_____

Do you have problems with any of the following:

☐ Yes ☐ No Dry/cracking skin

☐ Yes ☐ No Calluses

☐ Yes ☐ No Ulcers/non-healing sores

☐ Yes ☐ No Thickened/discolored toenails

☐ Yes ☐ No Infections/athlete's foot

☐ Yes ☐ No Deformity of your feet (e.g. Bunions)

☐ Yes ☐ No Ingrown toenails

☐ Yes ☐ No Amputation(s)

- DIABETES MEDICAL HISTORY FORM –

- Macrovascular Disease -

- Do Not Write In This Column -

Do you any of the following risk factors for heart disease and stroke?

☐ Yes ☐ No Have you had a heart attack? _____

☐ Yes ☐ No Have you had a stroke? _____

☐ Yes ☐ No Have you had a bypass procedure or a stent placed? _____

☐ Yes ☐ No Do you smoke or have you in the last 2 years?

☐ Yes ☐ No Do you have hypertension

☐ Yes ☐ No Have you been told your HDL level is low?

☐ Yes ☐ No Have you been told your triglycerides are high?

☐ Yes ☐ No Have family members had heart attacks and strokes younger than age 55? _____

☐ Yes ☐ No (Women) Are you still having periods?

Are you having any of the following symptoms?

☐ Yes ☐ No Chest pain with activity, after you eat or go out into cold air?

☐ Yes ☐ No Sudden loss of the use of a hand, arm foot or leg?

☐ Yes ☐ No Cramping pain in your calves that goes away when you rest?

Preventive Therapy

☐ Yes ☐ No Do you take an aspirin every day? Dose: _____ mg

☐ Yes ☐ No Do you use a statin? (Lipitor, Zocor, Crestor, Pravachol, Mevacor, Crestor)

☐ Yes ☐ No Have you ever had a BNP (B-type Natriuretic Protein) blood test?

- DIABETES MEDICAL HISTORY FORM –

- Mental Health –

☐ Yes ☐ No Past history of depression or other mental health issues

☐ Yes ☐ No Currently on therapy for depression or other mental health issues

_____

- Rheumatic Conditions –

☐ Yes ☐ No History of gout

☐ Yes ☐ No History of joint problems (Example: frozen shoulder)

_____

- Skin Lesions -

☐ Yes ☐ No History of necrobiosis lipoidica diabeticorum (lesions on your shins)

- Reproductive/Women's Health Issues -

☐ Yes ☐ No Have you been counseled about controlling your diabetes before becoming pregnant?

☐ Yes ☐ No Do you use contraception?
If yes, what type:

_____

Date of last Pap smear: _____

Date of last Mammogram: _____

Date of last Bone density: _____

- Dental Care -

☐ Yes ☐ No Do you see a dentist on a regular basis (once or twice each year)?

Date of last dental visit: _____

- Do Not Write In This Column -

- DIABETES MEDICAL HISTORY FORM –

- Immunizations -

- Do Not Write In This Column -

☐ Yes ☐ No Do you receive a flu shot each year?

Most recent: (year): _____

☐ Yes ☐ No Have you had a pneumonia vaccine? Year: _____

☐ Yes ☐ No Are you allergic to eggs?

- Social History -

Do you live: ☐ Alone ☐ With family ☐ Roommate(s)

Who do you live with: (e.g. wife, children)

_____

Marital status:

☐ Single ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Working ☐ Retired

☐ Home maker ☐ Disabled ☐ Unemployed

What hours do you work:

_____

☐ Yes ☐ No Do you drink alcohol?

(Type and Amount)

_____