Central Valley Endocrinology, PC

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DIABETES 1st VISIT QUESTIONNAIRE

NAME_____ Diabetes since _____(year diagnosed)
DATE_____ Primary Care Physician_____

1. How frequently do you check your sugar?_____per day / week (Circle). What meter do you use? _____.

2. What are your blood sugars at:

	RANGE	AVERAGE
BREAKFAST		
LUNCH		
DINNER		
BEDTIME		
AFTER MEALS		

3. Are you taking insulin? Y / N. (If yes, **when** was Insulin started? _____).
4. What is your insulin dose :

	Breakfast	Lunch	Dinner	Bedtime
Long Acting (Please Circle) NPH/ Lantus/ Levemir/ 70-30/Other (list)				
Short Acting (Please Circle) Regular/ Humalog Novalog/ Apidra				

5. How many low blood glucose reactions do you have per week / month?_____
(B) What time of the day are they most likely to occur? _____

6. ORAL MEDICATIONS FOR DIABETES: DOSE

METFORMIN(GLUCOPHAGE OR GLUCOPHAGE XR) _____
ROSAGLITAZONE (AVANDIA) _____
PIOGLITAZONE (ACTOS) _____
AVANDAMET or ACTOPLUSMET _____
GLUCOVANCE _____
GLIPIZIDE (GLUCATROL, GLUCOTROL XL) _____
GLYBURIDE (GLYNASE, MICRONASE, DIABETA) _____
AMARYL / GLIMEPRIDE _____
PRANDIN / STARLIX _____

7. Diet History

What do you eat for breakfast?

What snack do you eat before lunch?

What do you eat for lunch? At what time?

What snack do you eat before dinner?

What do you eat for dinner?

Have you seen a dietician in the past? When?

7. Last Hemoglobin A1C (Glycohemoglobin) result was _____(date)

8. Last visit with the eye specialist was _____(date). Any retinopathy Y / N

9. Other **diabetes complications**: Y / N (Please circle):
Kidney problems, Neuropathy, Foot ulcer /amputation, Heart Attack, Impotence.
Heart Attack, Heart Failure. Any other:

Patient Signature Date

_____ _____
Prem Sahasranam, M.D. (Reviewed with the patient) Date