Welcome to Hartford Healthcare Medical Group Endocrinology

DIABETES QUESTIONNAIRE

Name: _________________________ DOB: __________ Date:___________________

Questions and goals for this visit:

____________________________________
____________________________________

Have you ever been told you had diabetes? If yes, at what age?

_______________________________________________________________________________

Have you been told you have diabetes type 1, diabetes type 2, or gestational diabetes?

_______________________________________________________________________________

Have you ever been to a diabetes educator? If yes, most recent appointment:

________________________________________
_______________________________________

Have you ever been hospitalized for diabetic ketoacidosis, high blood sugars, or low sugars? If yes, when and where:

_______________________________________________________________________________

Aside from what is listed on your general intake form, are there diabetes medications you tried in the past that you no longer take? If yes, please list med and side effect or why they were discontinued.

________________________________________________________________________________

Do you forget to take your medications? If so, how often (once a day, once a week):

_______________________________________________________________________________

What is the most difficult part about managing your diabetes? (For example, running out of supplies, food choices, forgetting medications, forgetting to test sugar levels, stress, depression, finances, etc)

_______________________________________________________________________________

High and low sugars:
How often are you having low blood sugars? (please circle) Daily, weekly, monthly, rarely/never

How do you treat your low blood sugars? ____________________________________________

At what number do you feel your low sugars?_________________________________________

Have you had a severe low sugar causing a loss of consciousness or seizure? Y or N   If yes, please list when this occurred:_____________________________________________________________

Do you feel high sugars? Y or N

Diet:
Please list some examples of food from the past week:
Breakfast (time____):______________________________________________________________
Lunch(time____):_______________________________________________________________
Supper(time____):_______________________________________________________________
Snacks(time____):_______________________________________________________________
Drinks:__________________________________________________________________________

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Complications:
Have you been told you have any of the following complications from diabetes?
(please circle all that apply)

- Eye disease (retinopathy)
- Kidney disease (protein in the urine, nephropathy)
- Nerve damage (numbness, tingling, neuropathy)
- Heart attack/MI
- Mini-stroke/TIA
- Delayed gastric emptying (gastroparesis)
- Erectile dysfunction
- Autonomic neuropathy
- Stroke/CVA

When was your last dilated eye examination?
Date:________________________
Results:____________________
Office:_______________________

Last dental appointment (Month/Year):________________________

If you are on insulin:
Does it matter which insulin you take? (i.e. any insulin allergies)__________________
How often are you testing your sugar?_____________________________________
When are you testing your sugar?
(please circle)
- Fasting in the morning
- Before meals
- After meals
- No relationship to meals and when I test my sugar

If you are on an insulin pump:
How many years have you been on a pump?___________________________________
What other pumps have you been on in the past?_______________________________
Do you feel comfortable managing pump failure?______________________________
Do you know how to use ketostrips?_________________________________________
Do you know how to use glucagon?__________________________________________

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