Diabetes Questionnaire:

Producer:_____Phone:_____Fax:_____

Client:_____Age/DOB:_____Sex:_____

1. First Diagnosed:_____
2. How Often Does your client visit their physician?_____

3. The client's diabetes is controlled by
    a. Diet Alone
    b. Oral Medication_____(medication and doses)
    c. Insulin_____(amount of units/day)
4. Is your client on any other medications?
    a. Yes, please give details_____
    b. No
5. Please give the most recent blood sugar reading._____
6. Does your client monitor their own blood sugar?_____
7. What is the most recent glycohemoglobin (HbA1c) or fructosamine level?_____
8. Please check if your client has had any of the following:
    - ☐a. Chest paid or coronary artery disease
    - ☐b. Elevated lipids
    - ☐c. Kidney disease
    - ☐d. Black out spells
    - ☐e. Hypertension
    - ☐f. Overweight
    - ☐g. Protein in urine
    - ☐h. neuropathy
    - ☐ i. retinopathy
    - ☐ j. abnormal ECG
9. Has your client used tobacco in the last 12 months?
    a. If yes, please list type:_____ amount:_____
10. Does your client have any other major health problems (ex: cancer, etc.)?
    a. _____
    b. _____
    c. _____
11. Height and Weight:_____

Please email or fax back to:

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