**Etie Moghissi, MD, FACP, FACE**

**DIABETES HEALTH QUESTIONNAIRE**

Date:_____ Referring Physician:_____

Patient:_____
**(Last Name)** **(First Name)** **(Middle Initial)**

Date of Birth:_____ Sex: **___M ___F**

What is the reason for your visit today? _____

Date of diabetes diagnosis:_____

Type of Diabetes: **___Type 1 ___Type 2 ___Gestional ___Pre-diabetes ___Do not know**

Check the symptoms you had at the time of diagnosis:

**___Excessive thirst ___Excessive urination ___Weight loss ___Diabetic ketoacidosis**

**___Sever illness/hospitalization ___Other**

How your diabetes was treated initially? **___Insulin ___Pills**

Do you currently take insulin or any other injectable diabetes medications? **___Yes ___No**

If yes, what kind, how much, and how often?_____

Do you take pills for diabetes? **___Yes ___No**

If yes, what kind, how much, and how often?_____

Do you test your blood sugar at home? **___Yes ___No**

If yes, how often?_____

Do you keep a diary of your blood sugar? **___Yes ___No**

If yes, what is you meter? _____

What is your blood sugar range? _____

Do you experience low blood sugar reactions? **___Yes ___No**

If yes, how many times per week? _____

Have you ever had a severe low blood sugar reaction that had to be treated by someone else or that resulted in the paramedics being called? **___Yes ___No**

If yes, when?_____

Do you have warning symptoms of low blood sugar? **___Yes ___No**

Do have low blood sugar reaction at night? **___Yes ___No**

Do you have a glucagon kit at home? **___Yes ___No**

Do you test your blood sugar before you drive? **___Yes ___No**

Do you test your blood sugar before you exercise? **___Yes ___No**

How do you treat your low blood sugars? _____

Please continue on page-2

Do you follow a meal plan? ___**Yes** ___**No**

If yes, what kind?_____

Do you skip meals? ___**Yes** ___**No**

If yes, how often?_____

Do you snack between meals? ___**Yes** ___**No**

How often do you eat away from home?_____

Have you ever seen a nutritionist? ___**Yes** ___**No**

If yes, when and where?_____

Have you lost or gained weight recently? ___**Yes** ___**No**

If yes, how much? _____

Have you ever seen a diabetes educator? ___**Yes** ___**No**

If yes, when and where?_____

Do you exercise? ___**Yes** ___**No**

If yes, what kind of activity and how often?_____

Do you know what you A1C is? ___**Yes** ___**No**

If yes, when was it done?_____

Do you smoke tobacco? ___**Yes** ___**No**

If yes, how much?_____

Do you take aspirin? ___**Yes** ___**No**

If yes, how much and how often?_____

Do you drink alcohol? ___**Yes** ___**No**

If yes, how much and how often?_____

Do you suffer from any complications of diabetes? ___**Yes** ___**No**

If yes, what kind?_____

Do you see your eye doctor regularly? ___**Yes** ___**No**

Who is your eye doctor and when was your last eye exam? _____

Do you see a foot doctor? ___**Yes** ___**No**

If yes, when was your last foot exam? _____

Do have a heart doctor? ___**Yes** ___**No**

If yes, when was your last visit? _____

Please continue on page-3

**Etie Moghissi, MD, FACP, FACE**

**DIABETES HEALTH QUESTIONNAIRE**

Do you have any of the following conditions?

**___Heart disease ___History of heart attack, stent or pacemaker placement?**

**___Congestive heart failure? ____High blood pressure ____High cholesterol ____Thyroid condition**

**____Gastrointestinal problem ____Kidney disease ____Nerve damage ____Sexual dysfunction**

**____Pain or numbness in your feet? ____Depression? ____Cancer ___Other**

Please provide more information if you checked any of the conditions above:_____

_____

_____

What other medical conditions are you currently being treated for?_____

_____

Please list any hospitalizations or surgeries you may have had in the past:_____

_____

_____

Please list all of your medications, including the amount and how often you are taking it:_____

_____

_____

Please list all of your food and drug allergies:_____

_____

Is there anyone in your family with diabetes? **___Yes ___No**

If yes, who?_____

Are there any other medical condition in your family? **___Yes ___No**

If yes, describe them:_____

*Please use the back of this form to discuss any other issues or problems you would like to share*

***THANK YOU!***

Patient Signature:_____ Date:_____

Physician Signature:_____ Date:_____