Diabetes History Questionnaire

Please answer the following questions to the best of your ability.

Allergies: □ Yes □ No □ None known. If yes, to what? ____________________, ____________________, ____________________, ____________________, ____________________, ____________________, ____________________, ____________________, ____________________.

Medical History: Please check any conditions that you have.

☐ No medical conditions ☐ Headaches
☐ Arthritis ☐ Heart disease
☐ Bowel problem ☐ High blood pressure
☐ Cancer ☐ Hospitalizations for diabetes
☐ Cataracts ☐ Impotence
☐ Depression ☐ Kidney disease
☐ Diabetes ☐ Skin ulcer with diabetes
☐ Gout ☐ Stroke

Surgical History: Please check any of these that you have had.

☐ No surgeries ☐ Eye surgery
☐ Abdominal surgery ☐ Heart surgery
☐ Appendectomy ☐ Hernia surgery
☐ Artificial joints ☐ Hysterectomy
☐ Back surgery ☐ Kidney transplant
☐ Brain surgery ☐ Skin biopsy
☐ Breast surgery ☐ Thoracic surgery
☐ Broken bones/fractures ☐ Tonsillectomy
☐ Colon surgery ☐ Vascular surgery
☐ Cosmetic surgery

Family History: Please put a check in the square if your relative has a history of:

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Anemia</th>
<th>Cancer</th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>High Blood Pressure</th>
<th>High Chol</th>
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Patient Name: ___________________________
Date of Birth: ___________________________

Date: _____ / _____ / ________________
**Tobacco Use**
- Yes
- Never
- Quit
- Passive
- Years?
- Tobacco type?
- Packs/day
- Quit date

**Alcohol Use**
- Yes
- No
- Drinks/Week
- Glasses of wine
- Cans
- Bottles of beer
- Shots of liquor

**Recreational Drug Use**
- Yes
- No

### Medications

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<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
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**Pharmacy:** _________________________  **Phone number:** _______________________
Personal History:

Why are you coming to the diabetes education center today?
_________________________________________________________________________________________

What is your occupation? _________________________________________________________________

Number of hours worked in a week: ____________ What shift? ___________________

What school grade did you last complete? _________________________

How do you learn best? Please check: ☐ Listening  ☐ Reading  ☐ Observing  ☐ Doing

Diabetes History:

Have you been told by a health care provider that you have diabetes?  ☐ Yes  ☐ No
If yes, how long have you had diabetes? ____________________________________________________

Have you had any previous education about diabetes?  ☐ Yes  ☐ No

How satisfied are you with how you are managing your diabetes?
Please check: ☐ Not at all  ☐ Somewhat  ☐ Very

How confident are you in your ability to learn about diabetes and make some lifestyle changes to improve your health?
Please check: ☐ Not at all  ☐ Somewhat  ☐ Very

How important to you is making changes to improve your diabetes care?
Please check: ☐ Not at all  ☐ Somewhat  ☐ Very

Exercise:

Do you exercise regularly?  ☐ Yes  ☐ No
If yes:  Type of exercise: _________________________________________________________________

My exercise is: Please check: ☐ Easy  ☐ Moderately intense  ☐ Very intense

What are symptoms of diabetes that you have had in the past 4 weeks? (please check)
☐ None  ☐ Leg cramps
☐ Excessive thirst  ☐ Leg pains when walking
☐ Frequent urination  ☐ Leg pains when resting
☐ Weight loss  ☐ Fatigue
☐ Blurred vision  ☐ Chest pain
☐ Nausea or vomiting  ☐ Shortness of breath
☐ Stomach bloating  ☐ Numbness of hands
☐ Numbness of feet

Blood Glucose Control:

What gets in the way of you managing your diabetes? (please check)
☐ Nothing  ☐ Money
☐ Stress  ☐ Health problems
☐ Work  ☐ Lack of time
☐ Friends  ☐ Lack of knowledge
☐ Emotions  ☐ Family

Patient Name: ______________________________________
Date of Birth: ________________________________
Date: ______ / ______ / ________________________
Who helps you with your diabetes? (please check)

☐ No one  ☐ Healthcare Provider
☐ Family  ☐ Support Group
☐ Co-workers  ☐ Other ________________________________

Do you check your blood sugars? ☐ Yes  ☐ No

What meter do you use: __________________________________________

How often do you test? (please check)

☐ Once a day  ☐ Once a week
☐ 2 or more times per day  ☐ Occasionally
☐ Once a week

What is your target blood sugar range? ______________________________

Low blood sugar history:
Have you had any low blood sugar symptoms in the past month? ☐ Yes  ☐ No
If yes, how often have you had a low blood sugar? ________________________________
Can you tell the symptoms of a low blood sugar? ☐ Yes  ☐ No

How do you treat a low blood sugar? (please check)

☐ Nothing  ☐ Eat candy
☐ Take sugar  ☐ Eat food
☐ Drink juice

High blood sugar history:
Can you tell when your blood sugar is too high? ☐ Yes  ☐ No

What do you do when your blood sugar is too high? (please check)

☐ Nothing  ☐ Exercise
☐ Drink water  ☐ Take medication
☐ Drink broth  ☐ Call the doctor

Preventive Health:

When did you last see the eye doctor? ________________________________
When did you last see the dentist? ________________________________
When did you last have a flu shot? ________________________________
When did you last have a pneumonia vaccine? ________________________________

Learning Needs:

What topics do you need help with or would like to learn more about? (please check)

☐ None  ☐ Dealing with high or low blood glucose
☐ Meal planning  ☐ Managing diabetes when you are sick
☐ Eating out  ☐ Foot and skin care
☐ Exercise  ☐ Preparing for pregnancy
☐ Blood sugar monitoring  ☐ Impotence/sexual dysfunction
☐ Taking medications  ☐ Dealing with stress
**Other Individualized Needs:**

Do you have any religious, cultural or personal health beliefs that you would like considered as we help you develop your diabetes care plan?  □ Yes  □ No
If yes, what are they? ______________________________________________

Do you have difficulty with: Please check: □ Hearing  □ Seeing  □ Reading  □ Speaking

**Pain scale:**
Are you in pain today?  □ Yes  □ No
If yes, on a scale of 10 to 10 (0 being no pain) how would you rate your pain?
Please circle: 0  1  2  3  4  5  6  7  8  9  10
What causes your pain? ___________________________________________________________________

**Fall risk:**
Have you fallen within the last 3 months?  □ Yes  □ No
Do you use any ambulatory aids?  □ Yes  □ No
If yes, please check: □ Wheelchair  □ Cane  □ Walker  □ Other ________________________________

**Nutrition History:**

Height = _______________  Weight = _______________
Recent weight change: ______________________
Do you have a meal plan for diabetes?  □ Yes  No □
How often do you use this meal plan? _____________________________________________________

Patient Name: ________________________________
Date of Birth: ______________________________
Date: ______ / _____ / ______________________