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CENTER FOR MEDICINE, ENDOCRINOLOGY  
 AND DIABETES, LLC

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**DIABETES QUESTIONNAIRE** *(may continue answers on back)*

1. When were you diagnosed as having diabetes, what was your weight then, and what symptoms did you have?
2. What treatment did you receive initially?
3. Describe any changes in the treatment of your diabetes over the years and reasons for the changes?
4. How is your diabetes now being treated (name of oral agent, dose; type of insulin, dose, etc.)
5. How do you monitor your sugar (urine testing, blood testing, etc.)? How often do you do this? What results do you get?
6. Describe the diet you were given for your diabetes (calories, salt restriction, protein restriction, meals, snacks) and how well you are able to follow it.
7. Describe any exercise that you do regularly. What level of physical activity is required by your job?
8. What is your usual daily schedule (include times of diabetic medication, meals, snacks, exercise, work, etc.) How often does this schedule vary significantly? Describe.
9. Describe any previous diabetes education that you have had.
10. Are you familiar with the following topics?

	Yes	No	Want to know more/ Particular questions
Giving insulin	_____	_____	_____
Rotating injection sites	_____	_____	_____
Mixing Insulin	_____	_____	_____
Ketones	_____	_____	_____
Home glucose monitoring	_____	_____	_____
Sick day management	_____	_____	_____
Complications of Diabetes	_____	_____	_____
Foot Care	_____	_____	_____
Glucagon	_____	_____	_____
Stress management	_____	_____	_____

11. List and describe any hospitalizations that you have had for diabetes?

12. What concerns or feelings do you have regarding your diabetes?

13. Have you ever had any of the following problems?

<u>Problem</u>	<u>Now</u>	<u>In past</u>	<u>Explanation</u>
Excessive urination	_____	_____	_____
Excessive thirst	_____	_____	_____
Waking up at night to urinate	_____	_____	_____
Craving for sugar	_____	_____	_____
Being overweight	_____	_____	_____
Change in weight	_____	_____	_____
Low blood sugar	_____	_____	_____
Headaches	_____	_____	_____
Nightmares	_____	_____	_____
Night Sweats	_____	_____	_____
Tingling in hands/feet	_____	_____	_____
Numbness in hands/feet	_____	_____	_____
Burning/pain in hands/feet	_____	_____	_____
Blurred vision	_____	_____	_____
Retinal damage	_____	_____	_____
Retinal surgery	_____	_____	_____
Floaters/splotches in eyes	_____	_____	_____
Kidney disease	_____	_____	_____
Swelling of legs	_____	_____	_____
High blood pressure	_____	_____	_____
Heart failure	_____	_____	_____
Slow healing	_____	_____	_____
Chronic rash	_____	_____	_____
Yeast infections	_____	_____	_____
Babies over 9lb.	_____	_____	_____
Sexual problems	_____	_____	_____
Difficulty urinating	_____	_____	_____
Nausea after eating	_____	_____	_____
Diarrhea	_____	_____	_____

14. If applicable, please list the following:

Your eye doctor \_\_\_\_\_  
Your foot doctor \_\_\_\_\_  
Your kidney doctor \_\_\_\_\_  
Your family doctor \_\_\_\_\_  
Referring physician \_\_\_\_\_

15. If any member of your family has/had diabetes, please list the following information:

<u>Relative</u>	<u>Age of onset of diabetes</u>	<u>type of treatment</u>	<u>complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____