North Texas Diabetes & Endocrinology

Diabetes Questionnaire - Initial visit

Patient name: _____ DOB: _____/_____/_____

Date: _____/_____/_____

Year diagnosed with diabetes: _____

1. How frequently do you check your glucose level? _____ per/ ☐ day ☐ week

2. Do you wear a Continous Glucose Monitoring (DGM) device? ☐ yes ☐ no

3. What are your glucose numbers?

	Range	Average
Breakfast		
Lunch		
Dinner		
Bedtime		
After meals		

4. Are you taking insulin? ☐ yes ☐ no If yes, when did you start taking insulin? _____

5. What is your insulin dosage?

	Breakfast	Lunch	Dinner	Bedtime
Long acting:				
Short Acting:				

Sliding Scale? ☐ yes ☐ no

Insulin Pump? ☐ yes ☐ no

6. How many low blood glucose reactions do you have in a ☐ week ☐ month _____

7. Other medications for diabetes and dosage:

	Dose:
Jardiance/Farxiga/Steglatro/Invokana	_____
Metformin (Glucophage and Glucophage XR)	_____
Pioglitaone (Actos)	_____
Glipizide (Glucotrol and Glucotrol XL) / Glimepiride	_____
Prandin/Starlix	_____
Trulicity/Ozempic/Victoza/Bydureon/Rybelsus	_____

8. Last hemoglobin A1C (Glycohemoglobin) result was _____ Date: _____/_____/_____

9. Last visit with the eye specialist was on? Date: _____/_____/_____

10. Other diabetes complications: ☐ yes ☐ no

Kidney problems / Neuropathy / Foot ulcer / Amputation / Heart attack / Impotence / Heart Failure

Any other:

_____

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