Diabetes Questionnaire

atien	t name: Date of Birth:			
elf- re	eferral or referred by:			
rior e	ndocrinologist (if any):			
PLEA:	SE RETURN COMPLETED FORM VIA EMAIL PRIOR TO YOUR APPOINTMENT*			
	Circle one: Pre-diabetes / Type 1 diabetes / Type 2 diabetes Date diabetes was diagnosed:			
	How was it diagnosed (routine labs, symptoms, hospitalization)?			
4) Medications initially started for diabetes at diagnosis:				
5)	Name and doses of medications you are currently taking for diabetes:			
-	Do you take medications as prescribed?YesNo			
/)	Circle any other diabetes medications you have tried and that is not listed above:			
	Metformin Glipizide Glimepiride Glyburide			
	Pioglitazone Rosiglitazone Repaglinide Acarbose Pramlinitide			
	Victoza (Liraglutide) Trulicity (Dulaglutide) Ozempic/Wegovy (Semaglutide) Mounjaro/Zepbound (Tirzepatide)			
	Tradjenta (Linagliptin) Januvia (Sitagliptin) Onglyza (Saxagliptin)			
	Invokana (Canagliflozin) Farxiga (Dapagliflozin) Jardiance (Empagliflozin)			
	Glyxambi (Empagliflozin/Linagliptin) Synjardy (Empagliflozin/Metformin) Xigduo XR (Dapagliflozin/Metformin)			
	Humalog/lispro Novolog/aspart Lantus Levemir Regular insulin NPH Toujeo Tresiba 70/30 U-500			
	Other medications not listed above:			
	I have not used any other diabetes medications			
	•			
8)	How many times a day do you check your glucose (Circle one)?			

12) What did you eat and drink yesterday?			
Breakfast			
Lunch			
Dinner			
Snack			
xercise:			
yes, how many times a week and for how long?			
no, why?			
· ,			
13) Past medical history: Select if you have had or have	any of	these	
leart attack Stroke Peripheral arterial disease	K	idnev d	isease Thvroid
ysfunction Medullary thyroid cancer Pancreati		-	
Irinary tract infections Toe or other limb amputation			
,			
Have you had recent labs for hemoglobin A1C?	Yes	No	Details Date:
Do you take a cholesterol lowering medication?		 	Name:
Have you had a dilated diabetic eye exam?			Date:
Do you have diabetic retinopathy (damage to your eye)?			
Do you have diabetic neuropathy (nerve damage)?			
Have you had the pneumonia vaccine?			Date:
ymptoms (Circle if you have had any in the last 1 month)			
Fatigue fever weight gain weight l	oss	_	
Vision changes trouble swallowing			
		1 . 21	-11
Chest pain shortness of breath leg swelli	ng	_ paipit	ations
Diarrhea constipation decreased appetite	e :	abdomi	nal pain
Increased thirst frequent urination night	timo u	rination	
increased thirst frequent diffiation flight	time ui	illation	
Anxiety depression			
Intolerance to cold intolerance to heat			
		coroc or	your feet
Numbness or tingling in your hands or feetlesi	ons or s	sores or	i your reet
Numbness or tingling in your hands or feet lesi Pain in your hands pain in your feet joint			r your reet