

# Diabetes Questionnaire



Name:		
Date of Birth:		
1. When were you told you had diabetes?		
2. Type of diabetes?		
3. Name, address and telephone number of present attending physician(s):		
4. Frequency of visits to a physician:		Date of last visit:
5. Frequency of blood sugars:	Date and result of last blood sugar:	Method used:
6. Do you test your urine for sugar?	How often?	Method used:
7. Treatment:		
Diet:		
Insulin (type and dosage schedule):		
Oral medication (type and dosage of all):		
8. Has treatment changed during the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the changes:		
9. Have you ever had the following? Please provide dates, names, addresses and telephone number of attending physician(s).		
Diabetic coma? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Insulin shock? <input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nerve disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other complication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Do other members of your family have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, whom?		

Signature: \_\_\_\_\_

Date: \_\_\_\_\_