

DIABETIC PRE-APPOINTMENT QUESTIONS

DATE _____

PATIENT NAME _____ BIRTHDATE _____

BLOOD SUGARS

How often do you check your blood sugars? 1x daily 2x daily 3x daily 4x daily
Few times a week
I don't check my blood sugars
Other

Have you had low blood sugar episodes? Yes No

Have you had excessive thirst or urination? Yes No

Are you careful to watch a diabetic diet? Yes No Sometimes

BLOOD PRESSURE

Do you check your blood pressures? Yes No

If you check it, is it below 130/80? Yes No

SIDE EFFECTS/SYMPTOMS

Any Chest pain with activity? Yes No

Any Shortness of breath with activity? Yes No

Any all over muscle pain? Yes No

Any chronic cough? Yes No

Are you depressed? Yes No

PREVENTION

Do you exercise regularly? Yes No Sometimes

Do you smoke? Yes No

Do you take an aspirin daily? Yes No

Do you check your feet regularly? Yes No

Have you had an eye exam this year? Yes No

Did you get your flu shot this year? Yes No

Do you take your medications regularly? Yes No

Is your Pneumonia shot up to date? Yes No