DIABETIC PRE-APPOINTMENT QUESTIONS

DATE_____

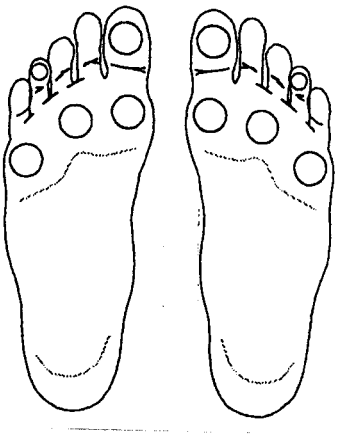
PATIENT NAME_____ BIRTHDATE_____

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	