Diabetes History Form
(Complete this form if you have diabetes
and bring it to your appointment)

Name: _____ Date of Birth_____ Date_____

When were you diagnosed with diabetes? _____ How old were you? _____

What type of Diabetes do you have? □ Type 1 □ Type 2 □ Don't know

Have you ever had any diabetes related complications? □ No □ Yes

- □ Stroke or TIA
- □ Peripheral vascular disease
- □ Dental problems or Gum disease
- □ Depression
- □ Diabetic eye disease
- □ Foot ulcers, deformities or amputations
- □ Pain /cramps in lower legs with walking
- □ Erectile dysfunction
- □ Skin ulcers or rashes
- □ Heart disease
- □ Neuropathy (nerve damage, numbness/tingling, burning feet or hands)
- □ Kidney problems (protein in the urine, abnormal kidney tests)

Have you ever been hospitalized for uncontrolled blood sugar? □ No □ Yes

How often do you have hypoglycemia (glucose less than 70)

- □ never
- □ occasionally
- □ weekly or more

Do you have symptoms with low glucoses? □ No □ Yes

How do you treat low glucoses?

- □ Glucose tabs
- □ Juice/soda
- □ Candy
- □ Other_____

Do you have symptoms with high glucoses? □ No □ Yes

Do you wear a medical alert ID? □ No □ Yes

When was your last eye exam? _____

How often do you check your blood glucose?

- □ never
- □ occasionally
- □ daily
- □ 2-3 times per day,
- □ 4+ times per day

(Bring your meter and or log book to all appointments)

Are you up to date with your pneumonia vaccine (once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccination) □ No □ Yes

Have you had a flu vaccination for this flu season? □ No □ Yes