DIABETES

Client name: ______________________________ DOB: ____________________

1. Diagnosis: ☐Type I ☐Type II Diagnosis Date: ____________________

2. Height: ____________________ Weight: ____________________

3. How often does client visit his/her physician? ____________________

   When was the last visit? ____________________

4. The diabetes is controlled by: (check all that apply)

   ☐ diet

   ☐ oral medication (name, dosage, start date) ____________________

   ☐ insulin (name, units per day, start date) ____________________

5. Please give the most recent blood sugar reading: ____________ Date:____________

6. Does client monitor his/her own blood sugar? ____________________

7. Most recent A1C:____________________ Date: ____________

8. Please check if client has (had) any of the following or check ☐ none

   ☐ albumin in urine ☐ overweight ☐ retinopathy
   ☐ protein in the urine ☐ insulin shock ☐ diabetic coma
   ☐ elevated lipids ☐ neuropathy ☐ abnormal ECG
   ☐ chest pain or coronary artery disease ☐ kidney disease ☐ hypertension

9. Does client have any other health issues? ☐No ☐Yes; please provide diagnosis and date.
   (additional questionnaires may be required)

10. Is client taking other medications? ☐No ☐Yes; please provide details below.

Medication Name and Dosage/Frequency	Start Date	Reason for Taking