DIABETES

Client name: ______________________________ DOB: ________________

1. Date first diagnosed: ________________ Height: _________ Weight: __________

2. How often does client visit his/her physician? ______________________________

   When was the last visit? ______________________________

3. The client's diabetes is controlled by: ☐ diet alone

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

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

4. Is client on any other medication(s)? ☐no ☐yes—name, dosage, start date and reason for taking: ______________________________

   ____

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

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

7. If available, what is the most recent glycohemoglobin (BhA1C) or fructosamine level?

   ______________________________ Date: ____________________

8. Please check if client has (had) any of the following:

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

9. List any other health issues, diagnosis & date. (Additional questionnaires may be required.)

Please submit the *Client Information Questionnaire* with this form.

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