

## HYPERGLYCEMIA



CLIENT NAME: \_\_\_\_\_

Submit the Client Information Questionnaire with this form

1. List date diagnosed: \_\_\_\_\_
  
2. What were the last 4 levels for:  
Glycohemoglobin: \_\_\_\_\_  
Glucose: \_\_\_\_\_  
Microalbumin: \_\_\_\_\_
  
3. Is condition controlled? \_\_\_\_\_
  
4. Is client taking any medication? (accurate name, dosage, and reason)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Does client have any other health issues?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_