NORTHEAST
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Diabetic Information Sheet

We want to help you manage your diabetes – please take a moment to fill out the following questionnaire:

Patient Name: _____ **Today's Date:** ____ / ____ / ____

When was your diabetes discovered (year)? _____

How was it treated? ☐ **Diet** ☐ **Pills** ☐ **Insulin** ☐ **Exercise**

Please list your current diabetes medication or insulin dose: _____

What medication for diabetes has been tried and discontinued? _____

Reason for discontinuation: ☐ **Didn't work** ☐ **Side effect (describe)** _____

What type of blood sugar monitor do you have? _____

How often do you test? _____ *When did you last change the batteries?* _____

Have you had a diabetic eye examination? ☐ **Yes** ☐ **No** Were your eyes dilated? ☐ **Yes** ☐ **No**

Name of eye doctor: _____

Do you have a diabetes related eye disease? ☐ **Yes** ☐ **No**

Do you have Diabetic Neuropathy (numb or painful feet, legs or hands)? ☐ **Yes** ☐ **No**

Have you had a urine test for Diabetic damage to the kidneys? ☐ **Yes** ☐ **No**

If yes, when? ____ / ____ / ____ Was the test positive or negative? ☐ **Positive** ☐ **Negative**

Please write the result of your most recent Hemoglobin A1C Test _____ **Date** ____ / ____ / ____

☐ *I don't know what a Hemoglobin A1C test is.*

Are you aware of proper foot care? ☐ **Yes** ☐ **No**

What is the most worrisome aspect of diabetes for you? _____

Where can improvements be made in your diabetes management? _____

What questions can we answer for you? _____