Name:
DOB

Diabetes Previsit Questionnaire

Since your last appointment in this office have you:	NO	YES	If new issue, please explain:
Been hospitalized or to the Emergency room?	____	____	_____
Had a new medical diagnosis or surgery?	____	____	_____
Had a family member with a new serious illness or death?	____	____	_____
Needed assistance to treat a low glucose reaction?	____	____	_____
Been wearing a Medic-Alert type bracelet or pendant?	____	____	_____
Had new foot problems (numbness, pain, skin lesions)?	____	____	_____
Experienced new visual changes?	____	____	_____
Had an eye care profession perform an eye exam?	____	____	_____

Date (approximate OK) of last eye care professional exam:_____ by: Dr._____

Regarding symptoms/problems:

Rate average energy past week (1=low, 10= high): _____/10

	No Problem	Yes, same	New Prob	Please explain:
a) Fevers				
b) Sweats				
c) Intolerance of heat or cold				
d) Trouble Swallowing				
e) Changes in voice				
f) Changes in hearing				
g) Chest Pains				
h) Heart Racing				
i) Swelling in legs (edema)				
j) Shortness of breath				
k) Cough				
l) Nausea or Vomiting				
m) Abdominal Pain				
n) Discomfort with urination				
o) Swelling or pain in joints				
p) Balance problem or falls				
q) Difficulty with memory				
r) Tremor				
s) Headache				
t) Skin rash or lesions				
u) Hair loss				
v) Bleeding/Bruising				
w) Allergic reactions				
x) Anxiety				
y) Depression				
z) Men: Erectile Dysfunction				
Women: Menstrual Change				

How often/much do you: wake up night to urinate?_____/night.

have a bowel movement? ____/day OR_____/week

Smoking: Packs per day: _____ or per week _____ OR NEVER _____

Alcohol Consumption drinks per day: _____ OR per week _____ OR Never _____