A. Reza Moattari, MD
Endocrinology,
Diabetes, & Metabolism

DIABETES MELLITUS HISTORY SHEET

Name: _____ Date: _____

Age: _____ DOB: _____

When was your diabetes first diagnosed? _____

Your age then? _____

What were your symptoms? _____

What was your blood glucose (sugar) then? _____

Did you have ketone (acetone) in your blood or urine? _____

Were you hospitalized? _____

On what treatment were you started? _____

Had you been told you had borderline sugar before that? _____

How long before? _____ How were you treated? _____

If female, how much did your largest baby weigh at birth? _____

How long ago? _____

Were you ever hospitalized for high blood glucose at any time after your diagnosis? _____

If yes, give the dates and circumstances: _____

What has been your highest blood glucose results in laboratory or in Doctor's office: _____

How much did you weigh when your diabetes was first diagnosed? _____

How much has your maximum weight been in your life? _____

How much has your minimum weight been in your adult life (after age 18)? _____

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Current Medications: (Include name of drug, dosage and how often taken, include over the counter, vitamins, supplements, etc. use the back of sheet if needed)

_____ _____

_____ _____

_____ _____

Any allergy to any medication? (Please list name of medication and type of reaction to drug)

_____ _____

_____ _____

_____ _____

Family History

Has there been any diabetes in your family? Yes _____ No _____

If yes, explain (age of onset and type of treatment)

Grandparents: _____

Mother: _____ Father: _____

Sisters: _____ Brothers: _____

Children: _____

Has there been anybody overweight in your immediate family? Yes _____ No _____

If yes, who?

_____

Has there been anybody with goiter, thyroid disease, Lupus, Rheumatoid Arthritis, Crohn's, permature menopause, pernicious anemia or Addison's disease in your family? Yes _____ No _____

If yes, explain _____

Has there been anybody in your family with coronary heart disease before age 55? Yes _____ No _____

If yes, explain _____

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Does anybody in your family have elevated blood lipid (cholesterol)? Yes _____ No _____

If yes, explain _____

Diet History

Have you ever seen a dietitian? Yes _____ No _____

Are you familiar with the exchange system? Yes _____ No _____

Are you familiar with carb counting? Yes _____ No _____

Are you currently on any special diet? Yes _____ No _____

If yes, how many calories and types? _____

Do you follow your diet? Yes _____ No _____ Sometimes _____

What is your greatest difficulty, if any, in following it? _____

_____

Do you ever skip meals? Yes _____ No _____

Give the approximate time of day for each of your meals as follows:

	Breakfast	Snack	Lunch	Snack	Supper	Snack
Meal times on work day	_____	_____	_____	_____	_____	_____
Who prepares the food	_____	_____	_____	_____	_____	_____
Meal times on non-work days	_____	_____	_____	_____	_____	_____
Who prepares the food	_____	_____	_____	_____	_____	_____

What days of the week are your working days (circle) M T W TH F S SU

How often do you eat outside? _____ per week Restaurant _____ Fast Food _____

Do you watch fat cholesterol content of the foods? Yes _____ No _____ Sometimes _____
Do you drink milk? Yes _____ No _____ How many glasses per day? _____

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How has your weight been in the last year? Lost _____ Gained _____ How much _____

Do you think you need to see a dietitian? Yes _____ No _____

Oral Antidiabetic Agents

Are you currently taking any oral medicine for your diabetes? Yes _____ No _____

If yes, give the name and dosage? _____

Have you ever been on oral medication for your diabetes? Yes _____ No _____

If yes, give the name, date and duration of therapy _____

Insulin

Are you presently taking insulin? Yes _____ No _____

Have you ever taken insulin in the past? Yes _____ No _____

If yes, please explain _____

What type of insulin(s) and how many units are you using? _____

Do you inject your insulin yourself? Yes _____ No _____

Circle places where your injections are given? Arms Legs Buttocks Abdomen

Do you rotate the site where you inject? Yes _____ No _____

Are there any lumps or pitting at your injection site? Yes _____ No _____

Has there been any recent changes in your insulin dosage? Yes _____ No _____

If yes, please explain the reason _____
What type of insulin syringe do you use? 0.3cc _____ 0.5 cc _____ 1 cc _____

Do you reuse the insulin syringe? Yes _____ No _____

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Do you adjust your insulin dosage? Yes _____ No _____

If yes, for what reason do you adjust it?

High or low blood glucose _____ Exercise _____ Meal _____ Sickness _____

Have you ever attended a diabetes education class? Yes _____ No _____

Blood Glucose Testing

Do you know how to check your blood glucose at home? Yes _____ No _____

Do you test your blood glucose at home? Yes _____ No _____

What brand of home glucose monitoring device (machine) do you use? _____

How often do you check your blood glucose? (Circle) Daily Weekly Monthly

How many times do you check your blood glucose? _____
per day_____per week _____ month ____

What were your most recent results? _____

Urine Testing

Do you test your urine for ketone (acetone)? Yes _____No _____

When do you check it? _____

What do you do if your urine acetone (ketone) is positive? _____

Low Blood Glucose (Hypoglycemia)

Were you ever hospitalized for low blood glucose at any time? Yes _____ No _____

If yes, give date and circumstances? _____

Have you ever had symptoms of low blood sugar? Yes _____ No _____

If yes, explain the symptoms _____

If no, do you know what are the symptoms of hypoglycemia? Yes _____ No _____

Please explain _____

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How often do you have hypoglycemia? _____

What time(s) of day do you have blood glucose symptoms? _____

What do you do when you have hypoglycemia? _____

Have you ever had seizure, coma or confusion due to hypoglycemia that needed hospitalization or help from somebody else? Yes _____ No _____

If yes, please explain the circumstances _____

Do you always carry some form of quick sugar with you? Yes _____ No _____

If yes, what type? _____

Have you ever used glucagon? Yes _____ No _____

If yes, please explain _____

Do you have glucagon kit at home? Yes _____ No _____

Does anybody close to you know how to give you glucagon? Yes _____ No _____

Diabetes Complication

When was your last visit to the eye doctor? _____

What type of doctor is your eye doctor? Optometrist _____ Ophthalmologist _____

Have you ever been told your diabetes has affected your eye (retinopathy)? Yes _____ No _____

If yes, please explain _____

Have you ever had laser treatment to your eyes? Yes _____ No _____

If yes, when and which eye _____

Have you ever been told your diabetes has affected your kidneys? Yes _____ No _____

If yes, please explain _____

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Do you have any numbness or tingling of hands or feet? Yes _____ No_____

If yes, how long _____

Can you feel pain and/or heat sensation in your feet? Yes _____ No _____

If no, please explain _____

Have you had any diabetic foot problems? Yes _____ No _____

If yes, please explain _____

Do you inspect your feet for any injury, callus or lesion every day? Yes _____ No _____

Do you easily get bloated and feel full after meals? Yes _____ No _____

If yes, please explain _____

Do you have diarrhea or constipation? Yes _____ No _____

If yes, please explain _____

Do you have decrease sexual desire? Yes _____ No _____

If yes, please explain _____

Do you have sexual dysfunction? Yes _____ No _____

If yes, please explain _____

Do you wear any emergency identification? Yes _____ No _____

Do you think that you need to see anybody for diabetes? Yes _____ No _____
(If yes, please circle) Diabetic Nurse Educator _____ Dietitian _____
Podiatrist _____ Psychologist/Psychiatrist _____
Other _____

If female in childbearing age: Are you planning to get pregnant in the future? Yes _____ No _____

If yes, do you know the effects of high maternal blood glucose on the baby? Yes _____ No _____

Do you know your blood glucose should be under very tight control even before conception to prevent malformation in the baby? Yes _____ No _____

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