

DIABETES PRE-VISIT QUESTIONNAIRE

Name _____

Date of visit ____/____/____

- 1. I check my blood sugar _____ times a day.
- 2. My fasting blood sugar readings range (check one) ____ 70-110 ____ 111-140 ____ 141-170 ____ 171-200 ____ >201
- 3. My blood sugars are highest in ____ morning ____ after eating ____ in the evening
- 4. I occasionally have low blood sugars ____ yes ____ no describe episodes _____
- 5. I am confident I know what to do if sugars are too high or too low. (Circle) (5 most confident) 1 2 3 4 5
- 6. I follow a diabetic diet ____ always ____ sometimes ____ rarely ____ never
- 7. Describe the diet you try to follow (you may check more than one):

- ____ low – fat eating plan
- ____ a calorie reduced diet
- ____ 5 servings of fruit and vegetables daily
- ____ low – carbohydrate, few sweets
- ____ other (specify): _____

- 8. Which of the following best describes your level of physical activity:
- ____ low to moderate activity (such as walking) on a daily basis
- ____ exercise continuously for at least 20-30 minutes _____ times a week
- ____ keep active in daily routine (stairs instead of elevator, household chores, park far from entrances)
- ____ other (specify): _____

- 9. I check my feet ____ daily ____ weekly ____ never for sores, cuts, calluses, redness.
- 10. Do you smoke ____ yes ____ no I am exposed to second hand smoke ____ yes ____ no

- 11. In the past 2 weeks, have you been bothered by:
- o Little interest or pleasure in doing things? ____ yes ____ no
- o Feeling down, depressed or hopeless? ____ yes ____ no

- 12. Check any of the symptoms you currently experience:
- ____ vision changes(vision loss, blurring) ____ dental problems ____ weight loss
- ____ fatigue ____ nausea, vomiting ____ diarrhea
- ____ chest pain or heaviness ____ dizzy/lightheaded ____ urinary frequency
- ____ short of breath ____ numbness in feet ____ weakness
- ____ palpitations ____ muscle/joint aches ____ increase thirst
- ____ leg swelling ____ headaches ____ sexual problems
- ____ other (specify): _____

13. Being a person with diabetes means: _____

14. When I think about having diabetes, I feel: _____

15. How do I feel about giving up old habits and starting new ones in order to improve my health? _____

16. Have you sought medical treatment outside of my office? ____ yes ____ no

17. I would be interested in participating in a group visit with my personal physician ____ yes ____ no

OFFICE USE

MA review _____ initials date ____/____/____

Physician review _____ initials