

NORTH TEXAS DIABETES & ENDOCRINOLOGY

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DIABETES 1st VISIT QUESTIONNAIRE

NAME _____ Diabetes since _____ (year diagnosed)
 DATE _____ Primary Care Physician _____

1. How frequently do you check your sugar? _____ per day / week (Circle). What meter do you use?
 _____.

2. What are your blood sugars at:

	<u>RANGE</u>	<u>AVERAGE</u>
BREAKFAST		
LUNCH		
DINNER		
BEDTIME		
AFTER MEALS		

3. Are you taking insulin? Y / N. (If yes, **when** was Insulin started? _____).

4. What is your insulin dose :

	Breakfast	Lunch	Dinner	Bedtime
Long Acting (Please Circle) NPH / Lantus / Levemir/ 70-30/ Novolog 70-30 Other (list)				
Short Acting (Please Circle) Regular/ Humalog/ Novalog/ Apidra				

For **insulin pump** users, please list basal and bolus rates in detail: Make: _____

Basal (units/hr): _____

Bolus: Carbs →.....Correction:

5. How many low blood glucose reactions do you have per week / month? _____

(B) What time of the day are they most likely to occur? _____

6. ORAL MEDICATIONS FOR DIABETES:

DOSE

- METFORMIN(GLUCOPHAGE OR GLUCOPHAGE XR) _____
- ROSAGLITAZONE (AVANDIA) _____
- PIOGLITAZONE (ACTOS) _____
- AVANDAMET or ACTOPLUSMET _____
- GLUCOVANCE _____
- GLIPIZIDE (GLUCATROL, GLUCOTROL XL) _____
- GLYBURIDE (GLYNASE, MICRONASE, DIABETA) _____
- AMARYL / GLIMEPRIDE _____
- PRANDIN / STARLIX _____
- BYETTA / JANUVIA _____

7. Last Hemoglobin A1C (Glycohemoglobin) result was _____ (date _____)

8. Last visit with the eye specialist was _____ (date _____). Any retinopathy Y / N

9. Other **diabetes complications**: Y / N (Please circle):

Kidney problems, Neuropathy, Foot ulcer /amputation, Heart Attack, Impotence.

Heart Attack, Heart Failure. Any other: _____