Name: _____
Date of Birth: _____
Today's Date: _____

# Diabetes

1. **Please circle which medications you are currently taking:**

   -Glyburide, glimepiride, glipizide, nateglinide (Starlix), Prandin, or similar
   -Metformin, glucophage or similar
   -Januvia, Janumet, Onglyza, Kombiglyze, Qtern, Nesina, Kazano, Tradjenta, Jentadueto, Glyxambi
   -Invokana, Invokamet, Jardiance, Synjardy, Farxiga, Xigduo, Steglatro, Steglujan, Segluromet
   -Byetta, Bydureon, Victoza, Trulicity, Ozempic
   -Soliqua, Xultophy
   -Symlin
   -Actos, Oseni
   -Acarbose
   -Cabergoline
   -Welchol, colesevalam
   -Afrezza
   -Insulin N, Lantus, Levemir, Basaglar, Tresiba, Toujeo
   -Insulin R, Humalog, Novolog, Apidra, Fiasp
   -Neuropathy medications: alpha lipoic acid, Metanx (or similar agent), Gabapentin (Neurontin), Lyrica

2. How many times a day are you checking your blood sugars? _____

3. How many meals a day do you have? _____

4. How many snacks do you have during the day? _____

5. Do you have liquid calories? Yes/No
   -Juice: _____ oz/day, _____ # times per week
   -Sodas (with sugars): _____ oz/day, _____ # times per week
   -Sweet tea (with sugar): _____ oz/day, _____ # times per week
   -Boost like products: _____ oz/day, _____ # times per week

6. How often do you exercise? _____ times a week
   How many minutes? _____
   WALKING / YOGA / JOGGING / SWIMMING / WEIGHTS /
   Other: _____

7. When was your last diabetes education class? _____

8. When was your last eye exam? _____
   Did you have retinopathy? **Yes/ No**; - Did you have glaucoma? **Yes/No**

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9. When was your last influenza vaccine? _____

10. When was your last Pneumovax (pneumonia vaccine)? _____

11. Have any of your family members had a…
    heart attack before age 55? **YES / NO**
    stroke before age 55? **YES / NO**

12. Current symptoms:
    -How many times per night do you have to wake up to urinate? _____
    -Since your last visit, have you gotten any yeast infections? **YES / NO** Any Urine infection? **YES / NO**

    Circle if you are experiencing any of the following:

**circle here if NONE of the BELOW**
- burning when urinating
- blood in urine
- chest pain/pressure/tightness
- shortness of breath
- dizziness/passing out
- leg swelling
- pain at the legs with walking
- cuts on the feet that don't heal
- numbness, tingling or burning at your feet
- nausea
- vomiting
- diarrhea
- constipation
- abdominal pain

13. If you did not bring your continuous glucose monitor or written sugars, please write them down the usual range of your sugars or sugars from the last 5 days on your meter if you brought it.

    Prebreakfast:

    2hrs after breakfast:

    Prelunch:

    2hrs after lunch:

    Supper:

    2hours after supper:

    Bedtime:

    Overnight:

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## DIABETIC PATIENTS WITH A PUMP:

Please record your current pump settings:

Total insulin (units per day):

| Device settings: | | |
|---|---|---|
| Basal (U/Hr) | Carb ratio (g/U) | Insulin sensitivity (mg/dL/U) |
| 12:00 AM: | 12:00 AM: | 12:00 AM: |