

Diabetes Patient Survey

To help me understand your current medical problem and symptoms, please complete the following questionnaire.

In a few words, please describe your condition and how I can help you today.

Have you been evaluated or treated by another doctor or other health care practitioner for this condition? If so, please describe. If not, please type "none".

What type of diabetes do you have?

- Type 1
 - Type 2
 - Gestational Diabetes (diabetes during pregnancy)
 - Other (please describe):
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How often do you check your blood sugar levels?

- Once daily
 - Twice daily
 - 3-4 times per day
 - Before each meal or snack
 - 2-5 times per week
 - Less than twice per week
 - Other (please describe):
-

Please list the medications you are taking to manage your diabetes including how often you take it and how much you are taking. Please be sure to update your medications list at the end of this webVisit. If you're not taking medication, please type "none."

Are you taking your insulin and/or diabetes medication as prescribed?

- Yes
 - Some of the time
-

Please describe why you are not taking your insulin and/or medications as prescribed. Select all that apply to you.

- I experience side effects (please describe):
- I am not sure how I should be taking my insulin and/or medication
- Dosaging schedule is difficult to keep
- I have ran out of insulin and/or medication
- I forget to take my insulin and/or medication as scheduled

- Difficulty paying for insulin and/or medication
- Other (please describe):
- No

Please describe why you are not taking your insulin and/or medications as prescribed. Select all that apply to you.

- I experience side effects (please describe):
- I am not sure how I should be taking my insulin and/or medication
- Dosaging schedule is difficult to keep
- I have ran out of insulin and/or medication
- I forget to take my insulin and/or medication as scheduled
- Difficulty paying for insulin and/or medication
- Other (please describe):
- Not taking any insulin and/or diabetes medication

What were your glucose/blood sugar levels over the past two days?

Please select the statement that best describes how often your glucose or blood sugar levels are within your target range.

- My glucose or blood sugar levels are within my target range more than 80% of the time
- My glucose or blood sugar levels are within my target range about half of the time
- My glucose or blood sugar levels are within my target range less than 20% of the time

Are you satisfied with how well your diabetes and blood sugars are being controlled?

- Yes
- Some of the time
- No

Have you experienced a change in your weight since your last visit or consultation?

- I've gained weight (enter pounds):
- I've lost weight (enter pounds):
- My weight has not changed
- Not sure

Have you experienced any of the following issues since your last examination or consultation? Select all that apply.

- Dizziness or light-headedness

Are you feeling dizzy or light-headed right now?

- Yes
 - No
 - Headache
-

- Numbness and/or tingling in feet and/or legs
 - Sores/wounds on feet
-

Do you currently have any open sores and/or wounds on your feet?

- Yes

Please describe where the sore/wound is on your foot, how large it is and what you have done to treat it.

- No

- Pain and/or discomfort in feet and/or legs
 - Chest pain and/or discomfort
-

Please select all of the following that apply to your chest pain.

- My chest pain is worse when I take a deep breath
- My chest pain comes on only after a coughing spell
- My chest pain comes on only after I exert myself
- My chest pain comes on when I am at rest
- My chest pain comes on by pressing on my chest wall, twisting, or moving my arms around
- My chest pain is "sharp"
- My chest pain is "dull" or more like pressure
- My chest pain is mostly in the center of my chest
- My chest pain is mostly in the left part of my chest
- My chest pain is mostly in the right part of my chest
- Other (describe):

How often do you experience chest pain?

- Several times per day
- At least once per day
- A few times per week
- At least once a week
- Once or twice over the last month
- Other (please describe):

- Vision changes
 - Fatigue and/or tiredness
 - Stress and irritability
 - Excessive thirst
 - Excessive urination
 - Blood sugar levels over 300
-

In the past month, how many times have your glucose/blood sugars values been above 300?

- 1-2 times
- 3-5 times
- More than 5 times
- Other (please describe):

When your glucose/blood sugar levels have been above 300, what have you done to lower your blood sugar? Please describe.

Blood sugar values below 70

In the past month, how many times have your glucose/blood sugars values fallen below 70?

- 1-2 times
- 3-5 times
- More than 5 times
- Other (please describe):

When your glucose/blood sugar levels have fallen below 70, what have you done to raise your blood sugar? Please describe.

- Episodes of sweating, anxiety, and palpitations that get better after eating or drinking
 - Other (describe):
 - None of the above
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Please list the date of your last eye examination. If you have not had an eye examination, please type "never."

Please list the date of your last foot examination by a physician or podiatrist. If you have not had a foot examination, please type "never."

Please describe your exercise routine. Include type of exercise, how many times per week you exercise, and how many minutes per session. If you are not exercising, please type "not exercising."

Please list the approximate date and reading of your most recent blood pressure test. If you have not had your blood pressure checked since your last visit or consultation, type "none."

Have you started taking any new prescription, over-the-counter medications, herbal remedies, and/or vitamin supplements? Please check all that apply to you.

- New prescription medication (name and dose):
-

- New over-the-counter medication (name and dose):
 - New herbal remedy (name and dose):
 - New vitamin supplement (name and dose):
 - Other (please describe):
 - Not taking anything new
-

Have your glucose/blood sugar levels changed since adding this/these new medications, over-the-counter medications, herbal remedies, and/or vitamin supplements?

- Yes
 - Yes, but only temporarily
 - No
 - Not sure
 - Not taking anything new
-

Would you like additional information on any of the following subjects? Select all that apply.

- How to better manage my diabetes and blood sugars
 - Understanding my HbA1c score
 - Controlling my blood pressure
 - Techniques for coping with living with diabetes
 - How to use my glucometer
 - Improving my diet/nutrition
 - How to lose or maintain my weight
 - How to manage my diabetes when I get sick
 - Stopping smoking
 - Starting an exercise program
 - How to manage stress
 - Sexual problems
 - How to lower my cholesterol
 - Managing all my medications
 - Is an Insulin pump right for me
 - Other (describe):
 - None of the above
-

Please enter any additional comments that you may have, or describe how I can help you.
