UW Medicine
NEIGHBORHOOD
CLINICS

DIABETES QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____ **TODAY'S DATE:** _____

What is your goal for today's visit? _____

_____

What is the most difficult issue for you in managing your diabetes? _____

_____

MEDICAL INFORMATION

Next Step to Health agreed upon at last visit successfully accomplished? …..……. ☐ Yes ☐ No

(If this is your first time filling out this form, then put your idea for the next step to better manage your diabetes in the comments below)

Comments: _____

_____

Are you taking your medications/insulin everyday? ….……..……..……. ☐ Yes ☐ No

Are you feeling well? ……..……..……... ☐ Yes ☐ No

Comments: _____

_____

Average home sugar readings:

Not testing: _____ Fasting: _____ 2-hours after meal: _____

Physical activity: _____ # times per week

Comments/how can we help? _____

_____

Doing well on a diabetic diet? ……... ☐ Yes ☐ No

Do you think a visit with our dietician will be helpful? ……. ☐ Yes ☐ No

Comments/how can we help? _____

_____

Tobacco use? ……... ☐ Yes (Ready to quit? ☐ Yes ☐ Not Yet) ☐ No

Comments/how can we help? _____

_____

CURRENT SYMPTOMS

Please check to indicate if you currently have any of the following symptoms:

☐ Vision Problems
☐ Numbness/Tingling
☐ Chest Pain
☐ Nausea/vomiting/diarrhea
☐ Low Blood Sugar Symptoms

☐ Additional issues to discuss with your provider today: _____

_____

CURRENT MEDICATIONS

What medications are you currently taking?

Name:	Dose/Units:	How many times a day?

OTHER COMMENTS:

_____

_____

_____

_____