KSB CENTER FOR DIABETES MANAGEMENT
PATIENT QUESTIONAIRE

GENERAL INFORMATION

Name:_______________________________________ Date Of Birth:_______ Age:____
Address:_____________________________________ Sex: Male / Female City:__________________
State:____ Zip:________
Phone (Home):_________________Work:_________________ Cell:_______________
Do you have access to the Internet? ☐ No ☐Yes (E-Mail address:_________________)
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race: ☐Caucasian ☐ Hispanic ☐ Asian ☐ African-American ☐Other:_____
Occupation:__________________________ Work hours/week:____________________
Number of people in household:__________ Last grade of school completed:_________
Is there a money issue that prevents you from getting good diabetes care? ☐Yes ☐No
If yes, please explain:____

DIABETES HISTORY

How long have you had Diabetes?____
What type of Diabetes do you have: ☐ Type 1 ☐ Type 2 ☐ Don't know
Family history of Diabetes: ☐ No ☐ Yes: (☐ Mother ☐ Father ☐ Siblings)
How would you rate your understanding of diabetes? ☐ Good ☐ Fair ☐ Poor
Have you ever been instructed on diabetes care? ☐ No ☐Yes:__________________
In your own words, what is diabetes?____
How do you feel about having diabetes?_______________________________________
What do you consider a "normal" blood sugar range? ___________ to _______________
Do you test your blood sugar? ☐ No ☐ Yes: Name of Meter_______________________
My diabetes has caused a problem in the following areas:
☐ Family/Social activities ☐ Work/school ☐ Finances
☐ Sexual relations ☐ Sports/exercise ☐ Travel
What areas of Diabetes would you like to learn more about?
☐ What is diabetes? ☐ Meal planning ☐ Medications ☐ Exercise
☐ Blood sugar testing ☐ Stress management ☐ Complications ☐ Sick days
☐ Insulin ☐ Insulin pump ☐ Other:_____________________
How do you learn best? ☐ Written materials ☐ Verbal discussions ☐ Video
Do you have any problems that make learning about diabetes difficult? ☐ No ☐ Yes
If yes, please list (hearing, sight, etc.)____

MEDICATIONS * Please bring all of your medications to your first visit*****

Are you allergic to any medications? ☐ No ☐ Yes: list___________________
Do you ever forget to take your medications?☐ No ☐ Yes
Do you take aspirin daily? ☐ No ☐ Yes
If you use insulin: do you inject with: ☐ Syringe ☐ Pen ☐ Pump
Where do you inject? ☐ Stomach ☐ Arms ☐ Legs
Do you re-use syringes? ☐ No ☐ Yes
Where do you dispose of needles/syringes?________________________

MEDICAL HISTORY

How would you describe your general health? ☐ Good ☐ Fair ☐ Poor

Is your health important to you?☐ All the time ☐ Sometimes ☐ None of the time

Current height:_______ Current Weight:________ Usual Weight:______

Do you smoke? ☐No ☐Yes: [Number of packs/day_____ Number of years_____]

Do you drink alcohol?☐ No ☐Yes: [Number of drinks/week______________________]

Do you have a lot of stress in your life at home or work/school? ☐ No ☐ Yes

Please check if you have any of the following problems

☐ Eye problems (retinopathy, cataract, glaucoma, macular degeneration, or other)
☐ Foot problems (neuropathy, numbness, foot sore, tingling, pain, or other)
☐ Kidney problems (nephropathy or other)
☐ Heart disease or heart failure
☐ High Blood Pressure (hypertension)
☐ Asthma or Emphysema
☐ Ulcers or heartburn (gastroesophageaol reflux)
☐ Arthritis
☐ Sexual dysfunction
☐ Depression or Anxiety
☐ Other medical problems: list:____

Date of last dilated eye exam:_________________

Date of last foot exam:_______________

How often do you check your feet? ☐ Daily ☐ Weekly ☐ Never

Date of last dental exam:________________

Have you been hospitalized in the last 6 months? ☐ No ☐ Yes

Have you been to the ER within the last 6 months? ☐ No ☐ Yes

Do you wear a medical identification bracelet or necklace? ☐ No ☐ Yes

Have you ever had a pneumonia shot? ☐ No ☐ Yes (Date ____________)

Have you ever had a flu shot? ☐ No ☐ Yes (Date____________)

EXERCISE

Do you exercise regularly? ☐ No ☐ Yes (if yes, please complete below)

What types of exercise do you do?_______________________________________

How often do you exercise?____

How long do you exercise?____

What time of day do you exercise?_______________________________________

Do you have any health problems that prevent you from exercising? ☐ No ☐ Yes

If yes, please list?____

Patient Signature:_____________________________________

Date:_____________________