Questionnaire for Patients with Diabetes

Patient Name: ____ Date: ____________________

- How long have you had diabetes? __________ Months __________ Years
- How many times a day / week / month (circle one) do you check your blood sugar? ________________
- Who checks your blood sugar? (circle one) You / Your doctor / Someone else
- What was your most recent hemoglobin A1C? ___________
  - When was it taken? ___________
- Are you taking medication for diabetes? Yes / No (circle one)
  If yes, name of medication: ____ Dose ______________
  - If you are on insulin, how long have you been taking insulin? ______ Weeks ______ Months ______ Years
  - Name of insulin used ____ Dosage ______________
- Do you have a history of foot sores that do not heal? Yes / No (circle one) If yes, which foot? Left / Right
- Do you have any loss of sensation in your feet or toes, including burning, tingling, and/or numbness? Yes / No
- Do you have cramping in your legs or feet? Yes / No
  - If yes, when? (circle all that apply) Walking / At Rest / At Night / Sitting
- Have you been hospitalized or had surgery in the last five years for a condition related to your diabetes? Yes / No
  - If yes, please explain: ____
- Do you see a diabetic specialist? Yes / No
  If yes, please complete the following:
  - Diabetic Specialist's Name: ____
  - Address ____
    ____
  - Date you were last seen ______ Month ______ Year
- Other than this office, have you ever seen a foot specialist? Yes / No
  If yes, please complete the following:
  - Foot Specialist's Name: ____
  - Address ____
    ____
  - Date you were last seen ______ Month ______ Year
- Have you ever owned diabetic shoes prescribed by a physician? Yes / No
  - If yes, who prescribed them? ____
  - Date prescribed: ______ Month ______ Year