Diabetes And Lipid Clinic
of Alaska

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Adult Diabetes History

Date:_____ Date of Diagnosis: _____

Name: _____

Address: _____

City:_____State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home phone: _____Work Phone: _____

E Mail: _____

Source of referral: ☐ Self referred ☐ Physician/Provider ☐ Other

Referring/Primary Care Provider and telephone number:

_____
Name Telephone

Family Heritage (Check all that apply):

☐ White ☐ American Indian/Alaska Native ☐ Black/African American

☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Spanish/Latino/Hispanic

Occupation: _____Hours worked per week: _____

Current Diabetes Treatment

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational

When were you first diagnosed with diabetes, and by whom?

_____

How was your diabetes initially treated? (*Diet, pills, insulin*)

_____

Have you ever had diabetes education? *When? Where? Was it useful?*

_____

If female, have you been diagnosed with gestational diabetes or have had children weighing more than 9 pounds at birth? ☐ Yes ☐ No

Do you have any complications related to your diabetes? (please check)

☐ Diabetic eye disease (Retinopathy)

☐ Nerve damage (Neuropathy)

☐ Kidney damage (Nephropathy)

☐ Stroke

☐ Heart disease

☐ Erectile or sexual dysfunction

☐ Skin problems

Date of last eye exam: ____/____/____ Eye Doctor: _____

Date of last dental exam: ____/____/____ Dentist: _____

Do you have any of the following health concerns?

☐ Thyroid disease
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Eye or vision problems
☐ Foot problems
☐ Numbness/pain in extremity
☐ Difficulty with sexual function
☐ Kidney problems
☐ Bladder problems

What type of medical problems or surgeries have you had in the past?

Diagnosis/Date

_____

_____

_____

_____

_____

_____

Medications

Please all of your medications, *prescription and OTC*

Name	Dose	Frequency	Doctor

Do you have any drug allergies or intolerances? What type of reactions did you experience?

_____

_____

Family Health History

Please check the disease state if you have a family history of:

☐ Diabetes If yes, whom: _____

☐ Thyroid disease If yes, whom: _____

☐ Heart disease If yes, whom: _____

☐ High blood pressure If yes, whom:

☐ Cancer If yes whom and what type: _____

_____

Other family illnesses _____

_____

_____

Diet History

Briefly describes your diet _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Has your weight changed in the past year? ☐ Yes ☐No How much? _____

Do you use alcohol? ☐ No ☐ Yes

How much and how often? _____

Do you use or have you used tobacco products?

_____

Do you exercise? If yes, what type? _____

How many times a week do you exercise? _____

How many minutes per exercise session? _____

Have you ever been advised by a doctor to limit your exercise in any way?

_____

What hobbies bring enjoyment to your life?

_____

_____

Describe your overall health

_____

_____

Self Blood Glucose Monitoring

Are you testing your blood sugar? ☐ Yes ☐ No

What type of meter do you have and how old is it? _____

Do you ever check for ketones? _____

What are your average glucometer readings?

A.M. _____Lunch _____Dinner _____Bedtime _____

Do you check your glucose after eating? If yes, what your values _____

_____

Do you know your last Hemoglobin A1c (3 month blood sugar test)?

If yes, what was it? _____

When was it done? _____

Do you have any low blood sugar reactions? _____

How often? When do they occur? _____

What warning signs do you feel when you have low blood sugar?

_____

How do you treat low blood sugar reactions?

_____

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

Do you have a glucagon kit at home for hypoglycemic emergencies? ☐Y ☐N

When and where was your last blood worked performed?

_____
Where When

Most Recent Lab Values

Total Cholesterol_____ Urine Microalbumin _____

HDL _____ Hemoglobin A1c _____

LDL _____ Triglycerides _____

Which type of vascular problems have you experienced in the past and what type of treatment was rendered?

_____

_____

Do you experience pain in your legs which is relieved by rest? How long do your symptoms last and when do you begin having these symptoms?

_____

_____

Do you have a history of "mini stokes" or strokes?

_____

Have you ever had an exercise stress test? Who performed it, where, and when?

_____

Have you ever undergone a heart catheterization (dye injected into heart arteries)? Who performed it, where, and when?

_____

_____

Have you ever had an ultrasound (Doppler) of your carotid arteries?

_____

_____

What are your health care goals and how can we facilitate those goals?

_____

_____

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____