BMG | THE ENDOCRINE CLINIC

DIABETES DATA BASE

Name: ______________________ Date of Birth: ______________ Today's Date: __________

INSTRUCTIONS: PLEASE CHECK THE APPROPRIATE BOX AND ADD COMMENTS.

Date of Diagnosis: Month: ______________ Year: ______________

History of Diagnosis (include where, by whom, follow-up, blood glucoses and symptoms):

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DIABETES MONITORING:

a. checking: ☐ blood sugar ☐ urine ketones ☐ nothing

b. frequency: times per day: ________ days per week: ☐ everyday ☐ other: ____________

c. brand of testing device(s): ______________________

d. average blood sugar (if known): AM: ______ Lunch: ______ Supper: ______ Bedtime: ______ Other: ______

Last Hemoglobin A1c: ________ ☐ Unknown

Is there a history of:

- Eye damage from diabetes: ☐ Yes ☐ No
- Diabetic nerve damage to feet/hands: ☐ Yes ☐ No
- Sexual problems: ☐ Yes ☐ No
- High blood pressure: ☐ Yes ☐ No
- Heart attack, stroke or other heart problems: ☐ Yes ☐ No
- Diabetic kidney problems or protein in urine: ☐ Yes ☐ No
- High cholesterol / triglycerides: ☐ Yes ☐ No
- Tobacco use: ☐ Currently yes ☐ Past Yes ☐ Never

  Describe: ______________________

CURRENT DIABETES PLAN INCLUDES

☐ Diabetes pills: (list CURRENT types/doses/times/per day) ______________________

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☐ Insulin regimen:
a. list types/doses & times of doses: ______________________
b. do you use: ☐ insulin vial ☐ insulin pen (brand): ______________________
c. rotation of injections to: ☐ stomach ☐ arm ☐ thigh ☐ hip ☐ other: ____________

☐ If insulin pump:
a. brand/model of pump: ______________ basal rate(s): ______________
b. how much bolus insulin do you give pre-meals & how much do you calculate bolus adjustments:

____

☐ Nutritional / Diet plan: ☐ carbohydrate counting ☐ ADA calories ________ ☐ low fat/cholesterol ☐ other ________

☐ Exercise Plan: Type: ______________ Frequency: ____________ How many minutes each time? ________

☐ Do you take an aspirin daily? ☐ Yes ☐ No Dose: ________ mg

☐ Do you wear a medic-alert bracelet/necklace? ☐ Yes ☐ No

☐ Do you have glucagon at home? ☐ Yes ☐ No

☐ Are you an ADA/JFD member? ☐ Yes ☐ No

☐ Are there sugar raising food/supplies in the car? ☐ Yes ☐ No

☐ Have you seen an eye doctor in the last year? ☐ Yes ☐ No

☐ Do you perform routine foot care? ☐ Yes ☐ No

METABOLIC IMBALANCE

a. Diabetic Ketoacidosis: ______________________ ☐ None

b. Coma from high or low blood sugar: ______________________ ☐ None

c. Low blood sugars: frequency: ______________ most likely times of day: ______________ ☐ None

Explain please: ______________________