Diabetes History Form (Complete this form if you have diabetes and bring it to your appointment)

Name:	Date of Bir	th	Date
When were you diagnosed with diabetes?		How old were you?	
What type of Diabetes do you have	? 🗆 Type 1	□ Type 2	🗆 Don't know
Have you ever had any diabetes related complications? □ No □ Yes			
□ Stroke or TIA		Foot ulcers, def	ormities or amputations
Peripheral vascular disease		Pain /cramps in	n lower legs with walking
\Box Dental problems or Gum dis	sease	Erectile dysfund	ction
Depression		Skin ulcers or r	ashes
□ Diabetic eye disease		Heart disease	
□ Neuropathy (nerve damage, numbness/tingling, burning feet or hands)			
\Box Kidney problems (protein in the urine, abnormal kidney tests)			
Have you ever been hospitalized for How often do you have hypoglycem	uia (glucose le	ess than 70)	□ No □ Yes
□ Other Do you have symptoms with high glucoses? □ No □ Yes			
Do you wear a medical alert ID?			
When was your last eye exam? How often do you check your blood never occasionally daily 2-3 times per day, 4+ times per day (Bring your meter and or log book t	l glucose?	tments)	
Are you up to date with your preumonia vaccine (once before the age of 65 and once after the			

Are you up to date with your pneumonia vaccine (once before the age of 65 and once after the age of 65 but not within 5 years of a previous pneumonia vaccination) Have you had a flu vaccination for this flu season? No Yes