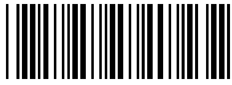


Welcome!

JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

DIABETES FIRST VISIT QUESTIONNAIRE

Name ______________________ Date ______________________

Your Date of Birth ______________________ Age ______________________

YOUR DIAGNOSIS OF DIABETES

About when were you diagnosed with diabetes? ______________________

How diagnosed? ______________________

Max weight before diagnosis ______________________ Change in weight since diagnosis ______________________

DIABETIC MEDICATION

Do you take pills for diabetes? ☐ No ☐ Yes If yes, for how many years have you taken the pills? __________

Type of Pills	Dose	Type of Pills	Dose	Type of Pills	Dose

Do you take insulin? ☐ Never ☐ Not now ☐ Yes If yes, Please fill in insulin types and dose (units):

Morning	Lunch	Supper	Bedtime

Do you use an insulin pump? ☐ No ☐ Yes Type ______________________

BASAL RATES:

	Time	Units/hr
Example:	Midnight	0.8 units/hr

BOLUS:

Nutritional Dose: 1unit/__________ grams carb

Example: 1 unit for every __10__ grams carb

For High Blood Sugars:

Correction dose: 1 unit for every _____ over _____

Example: 1 unit for every __30__ over __120__ (mg/dl)

PLEASE DESCRIBE YOUR DIET

Check all that apply.

High in: ☐ Sweets ☐ Fats ☐ Fried Foods ☐ Fast foods ☐ Carbohydrates ☐ Fiber ☐ Lean meats ☐ Vegetables ☐ Fruits

Potatoes: ☐ White ☐ Sweet ☐ None

Bread: ☐ White ☐ Wheat ☐ Whole grain ☐ None

Rice: ☐ White Brown/wild ☐ None

Pasta: ☐ White ☐ Wheat ☐ High fiber ☐ None

Cereals: ☐ Sugary ☐ Whole grain ☐ High fiber ☐ None

How many servings of fruits/vegetables daily? __________ How many servings of red meat per week? __________

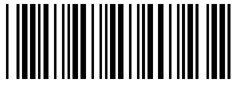
How many calories would you estimate you eat each day? ______________________

HOW MUCH DO YOU EXERCISE?

Type	Frequency	Type	Frequency	Type	Frequency

JHOC DIABNPQ NL A (11/10)

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help. We want you to live a healthier life.



HOW WELL IS YOUR DIABETES CONTROLLED?

In your opinion, is your control: ☐ Excellent ☐ Pretty Good ☐ Not so good ☐ Poor

Do you test your blood sugar? ☐ No ☐ Yes If yes, how often? ____________________

Typical blood sugar range of self monitoring results (please fill in any/all that apply):

AM (fasting)	2 hours after	Lunch	2 hours after	Dinner	2 hours after	Bedtime

A1c results you know by date: ____________________

____

Compared to the past, is your control: ☐ Better? ☐ About the same? ☐ Worse?

DO YOU EVER HAVE HYPOGLYCEMIA (LOW BLOOD SUGAR)?

☐ Yes ☐ No If no, skip to next section.

About how often do you feel low? ☐ Daily? ☐ Weekly? ☐ Monthly? ☐ Rarely?

What are your low blood sugar symptoms? ____________________

What time of day are lows most typical? ____________________

Are you ever low overnight? ☐ No ☐ Yes Do you wake up? ☐ No ☐ Yes

Have you ever been in a diabetic coma? ☐ No ☐ Yes

When is the last time you needed help from someone to treat a low? ____________________

WHAT ARE THE MAIN DIABETES ISSUES YOU WANT HELP WITH?

____

____

____

____

PAST MEDICAL HISTORY

What operations (surgeries) have you had in your life, and about what year?

Type of Surgery	Approximate Year	Type of Surgery	Approximate Year

OTHER MEDICAL ILLNESSES

What other medical illnesses do you have? (Such as high blood pressure, high cholesterol, heart attack, or stroke?

____________________ ____________________ ____________________ ____________________

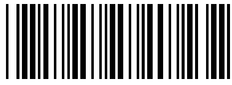
____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Hand Washing is Important to Stop the Spread of Illness and Infection

Wash Your Hands After:

- **(and before!) Handling food or eating.**
- **Using the bathroom or changing diapers.**
- **Sneezing, coughing or blowing your nose.**
- **Touching a cut, open sore or wound.**
- **Playing outside.**
- **Playing with pets or cleaning up after them.**



FAMILY HISTORY

Relatives with diabetes ______

Does heart disease or stroke occur at an early age (under 55 years old) in your family? ☐ No ☐ Yes

If yes, state which family members, and age ______

Does high cholesterol run in your family? ☐ No ☐ Yes

SOCIAL HISTORY

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

Are you employed? ☐ No ☐ Yes ☐ Retired Your Occupation ______

How many years of schooling have you completed? ______

Do you have children? ☐ No ☐ Yes If yes, you many?______

TOBACCO/ALCOHOL/DRUGS HISTORY

Tobacco ☐ Never ☐ Cigarettes ☐ Cigars ☐ Snuff ☐ Quit If you quit, when? ______

Packs per day______ Number of years______ We DO recommend a smoking cessation program

Alcohol ☐ Never ☐ Special Occasions Number of drinks/week ______

Illicit drugs ☐ No ☐ Yes (Please list) ______

FOR WOMEN OF CHILDBEARING AGE

Contraceptive currently used ______

Pregnancy planning? ☐ No ☐ Yes

Number of pregnancies______ Number of deliveries______ Number of terminations or miscarriages______

Number of children alive______ Ages______ Birth Weights ______

Illnesses? ☐ No ☐ Yes______ Babies Premature? ☐ No ☐ Yes If yes, how many? ____

REVIEW OF SYMPTOMS

Any RECENT problems with the following? ☐ No If Yes, please check:

☐ **Fever**

☐ **Weight change** (how much in past 3 months?)_____

Eyes: ☐ blurred vision ☐ loss of vision
☐ laser surgery ☐ history of diabetic retinopathy
Date of last dilated eye exam ______

Ear, nose, throat: ☐ sinus pain or congestion
☐ dental problems ☐ throat pain

Cardiovascular: ☐ chest pain
☐ swelling of the legs ☐ pain/cramps in the calves of the legs when walking that gets better with rest

Respiratory: ☐ shortness of breath
☐ decreased exercise tolerance

GI: ☐ nausea and/or vomiting following meals
☐ diarrhea ☐ constipation

GU: ☐ excessive thirst ☐ frequent urination

Men: ☐ difficulty attaining or maintaining erections

Women: ☐ irregular menstrual cycles
☐ loss of menstrual cycles ☐ hot flashes

Nerves: ☐ numbness in feet
☐ loss of sensation in the feet
☐ pain or burning in feet ☐ dizziness on standing

Feet: ☐ callouses or ulcers

Skin: ☐ rashes

Psych: Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things (check one)
☐ not at all ☐ several days
☐ more than half the days ☐ nearly every day

Feeling down, depressed, or hopeless (check one)
☐ not at all ☐ several days ______
☐ more than half the days ☐ nearly every day

Musculoskeletal: ☐ joint pain ☐ muscle pain
If so, what location? ______

On a scale of 0 (none) to 10 (severe), how would you rate your pain today? _____

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