

DIABETES AND OTHER GLUCOSE METABOLISM DISORDERS QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM/DD/YY		

2. DIAGNOSIS

Please provide details about when the condition was diagnosed.

Date of first symptoms	MM/DD/YY	Date of diagnosis	MM/DD/YY
------------------------	----------	-------------------	----------

Type of diabetes Type 1 diabetes (Insulin-dependent) Type 2 diabetes (No insulin-dependent) Gestational diabetes

Is the patient under treatment? Yes No If "Yes", please provide details.

Diet	Specify type of insuline and units
Oral medication (NAME/DOSAGE)	Combination (EXPLAIN)

Has the patient had any of the following complications? If "Yes", please explain:

Condition	Date of first symptom	Condition	Date of first symptom
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	Interment claudication <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY
Macroangiopathy/ Microangiopathy <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	Skin disorders (Eruptive xantomathosis, Ulcers, diabetic dermatopathy, Necrobiosis lipoidica etc) <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY
Retinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY
Neuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	Other complications <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY
Nephropathy <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	Hospital admissions <input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY

Please provide the following information:

Date	MM/DD/YY	Height <input type="checkbox"/> M <input type="checkbox"/> Ft	Weight <input type="checkbox"/> Kg <input type="checkbox"/> Lb
------	----------	---	--

Values of blood test results performed within the past 6 months (please include the lab report):

Fasting glucose	Glyco hemoglobin	Total Cholesterol	Triglicerides
LDL	HDL	BUN (Relation Urea/Creatinine)	Creatinine

Specimen test results performed within the past 6 months (please, include the lab report):

Has the patient undergone any of the following studies? If "Yes", please explain. (PLEASE INCLUDE REPORTS)

Study		Date	Result
Creatinine clearance	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	
24-hour proteinuria	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	
Glucose tolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	
Microalbuminuria	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	MM/DD/YY	

3. TREATING PHYSICIAN'S INFORMATION

Name			
Address			
Telephone		Fax	
E-mail			
Signature		Date	MM/DD/YY