Yale Medicine

Yale Diabetes Center

NEW PATIENT HEALTH QUESTIONNAIRE

Please complete this form and bring it with you to your visit. It will let you to get the most out of your visit. Your provider will review this information in detail at the time of your appointment.

Your Name: _____ Your Age: _____

Referring Physician: _____ Town: _____

Primary Care Physician: _____ Town: _____

OTHER PHYSICIANS YOU SEE:

_____

_____

I. Diabetes History (if you don't have diabetes, skip to section VI)

1. What type of diabetes you have? ☐ Type 1 ☐ Type 2 ☐ Unknown
2. Date of diagnosis: _____ or, age at diagnosis: _____

II. Current Medications

Please list all medications you are currently taking, including all current vitamins, dietary supplements and "over the counter." You do NOT need to include insulin here.

Diabetes medications	Dosage of medication	Frequency

Other medications	Dosage of medication	Frequency

For accessibility assistance, please contact Yale Medicine CARE Center at 1-877-YALEMDS.

III. Injectable Insulin

1. How frequently do you inject insulin each day? _____

2. Please list your insulin doses:

INSULIN NAME	DOSE (UNITS)	TIME OF DAY

3. Do you use a sliding scale or correctional dose? ☐ Yes ☐ No

   If yes: Please describe: _____

IV. Pump Insulin

1. What type of pump do you use? _____

2. What type of insulin do you use with the pump?

   ☐ Lispro (Humalog) ☐ Aspart (Novolog) ☐ Glulisine (Apidra)

3. Please list your basal rates:

FROM (HH:MM)	TO (HH:MM)	BASAL RATE

4. Please describe any rules you follow to correct high blood sugars: _____

5. Please describe your meal bolus dosing plan (e.g., insulin to carb-ratio, etc): _____

6. On average, what is the total amount of insulin you use on a daily basis? _____ units

V. Blood Sugar Monitoring

1. What times of the day do you check your blood sugar?

   ☐ Before breakfast ☐ After breakfast

   ☐ Before lunch ☐ After lunch

   ☐ Before dinner ☐ After dinner

   ☐ Before bedtime ☐ At 3 A.M. or early morning

   ☐ Other, list: _____

   _____

2. Which meter do you use to check your blood sugar? _____

3. What is your most recent hemoglobin A1C? _____ % ☐ I Don't know

VI. Diabetes Complications

1. Do you have eye complications from diabetes (retinopathy)? ☐ Yes ☐ No
   When was your last eye exam? _____ Where was it done? _____

2. Do you have protein in the urine? ☐ Yes ☐ No ☐ I don't know

3. Do you have nerve damage from diabetes (neuropathy)? ☐ Yes ☐ No
   If yes: ☐ Numbness, tingling, or decreased sensation in hands/feet
   ☐ Burning pain in your feet ☐ Foot ulcers or sores

4. Do you see a foot doctor (podiatrist)? **If yes,** date of last visit: _____

5. Do you have high cholesterol? ☐ Yes ☐ No ☐ I don't know

6. Low Blood Sugars (Hypoglycemia):
   A. Do you suffer from low blood sugars? ☐ Yes ☐ No
      i. **If yes:** how frequently? _____
      ii. What symptoms do you get when your sugar is low? _____
      iii. At what blood sugar do you begin to have symptoms? _____
      iv. Is there a particular time of the day when your blood sugars get too low:
      ☐ Yes ☐ No **If yes,** when? _____

   B. Have you ever required the help of others because of low blood sugar? ☐ Yes ☐ No

   C. Have you ever had loss of consciousness or a seizure because of low blood sugar?
   ☐ Yes ☐ No **If yes,** when? _____

7. High Blood Sugars (Hyperglycemia):
   A. Have you ever been in diabetic ketoacidosis (DKA)? ☐ Yes ☐ No **If yes,** when? _____

VII. Diet

1. How many meals do you have on a typical day? _____

3. Do you 'count carbohydrates'? ☐ Yes ☐ No

VIII. Exercize

1. Do you exercise regularly? ☐ Yes ☐ No
   If yes: What type? _____

   How frequently? _____

   For how long (minutes)? _____

IX. Habits

1. Do you drink any alcohol? ☐ Yes ☐ No **If yes,** how much? _____

2. Do you smoke? ☐ Yes ☐ No **If yes,** how much? _____

X. Demographics

1. Marital status: ☐Married ☐ Single ☐ Divorced ☐ Partner deceased

2. Home situation (check one): ☐ Live alone ☐ Live with (list): _____

3. Occupation: _____

XI. OB-GYN history (women)

1. Number of pregnancies & number of births? _____

2. Diabetes during pregnancy? ☐ Yes ☐ No

3. Last menstrual period? _____

XI. Allergies

1. Please list medications and indicate what kind of reaction you have ☐ No allergies

   _____

XII. Other Medical Conditions/Surgeries

1. Please list any illness you have had and the time of diagnosis.

_____

_____

_____

_____

_____

_____

XIII. Vaccinations

1. Influenza (Flu) ☐ Yes ☐ No Date: _____
2. Pneumonia ☐ Yes ☐ No Date: _____

XIV. Family History

1. Please list the diseases that run in your family, indicate relative and age of diagnosis, if known.

_____

_____

_____

_____

_____

_____

Your Signature: _____ Date: _____

I have reviewed this completed document with the patient.

MD/APRN Signature: _____ Date: _____

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