

Sameer Stas, M. D. - Diabetes QUESTIONNAIRE (3 pages)
SUSSEX COUNTY MEDICAL ASSOCIATES
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Patient Name: _____ **DOB:** _____

- 1) What Type of diabetes do you have? Type 1 Type 2 Don't know
- 2) When were you diagnosed with Diabetes? Month _____, Year _____
- 3) How was it discovered?

- Screening program Regular checkup In hospital
- Had symptoms of diabetes Other: _____

- 4) Have you been admitted to the hospital for:
 - your diabetes? Yes No
 - Diabetic ketoacidosis? Yes No
 - Severe hyperglycemia? Yes No
 - Severe hypoglycemia? Yes No
 - Starting insulin? Yes No
 - Other: _____

- 5) Are you aware of any complications from your diabetes? Yes No
- If yes, what?
 - Kidney damage Eye damage Nerve damage Amputations
 - Foot problems Heart disease Other: _____

Diet

- 6) Were you given a MEAL PLAN? Yes No
- By whom? Dietician Physician

- 7) Are you familiar with carbohydrate counting? Yes No
- Do you apply it? Yes No

8) Approximate daily calories: _____

9) Usual times for meals: Breakfast _____
Lunch _____
Supper/Dinner _____

- 10) What is your biggest meal? Breakfast Lunch Supper/Dinner

- 11) Do you snack regularly? Yes No
- When? _____

- 12) Are you on any special diet? Low fat Low sodium Low protein
- Other: _____

13) How often do you eat out? _____

Physical Activity

- 14) What is your current occupation? _____
- 15) What are your usual work hours? _____
- 16) How much physical work does it take? _____
- 17) Do you exercise regularly? Yes No
- What sort of exercise? _____

Treatment

- 18) Have you had any treatment for diabetes? Yes No
- 19) Are you on an insulin pump? Yes No

What Model? _____

What are the settings? (If you know) _____

- 20) Are you taking oral medications? Yes No
- Please List:

Name	Strength?	How often?

- 21) Are you taking injections for diabetes? Yes No

Name	How many units?	How often?

- 22) Do you adjust your insulin dose based on your blood sugar or what you eat? Yes No

Monitoring

- 23) How often you check you blood sugar? _____ times a day
 _____ times a week
 _____ times a month or I do not check

What time of the day do you usually check? _____

Hypoglycemia

24) Have you had low blood sugars (insulin reactions)? Yes No
How often? _____ times a week _____ times a month
Usually: Mild Moderate Severe Very Severe (need help from others)
Do any come without warning? Yes No
When do they usually happen?
 At night Morning Before lunch Afternoon Evening
Is there a good reason for them? Yes No Extra exercise Less food
How do you usually deal with them? _____

25) Do you carry emergency supply of food or sugar? Yes No
What? _____

26) Do you wear a DIABETES ID bracelet or necklace? Yes No

27) Have you received an education about diabetes? Yes No

28) Have you been in Diabetes Education Program? Yes No

When? _____

29) Do you have your eyes checked every year? Yes No

When was the last time you had your eyes checked? _____

By whom? _____

30) Do you have foot problems? Yes No

What? _____

31) Do you see a foot doctor? Yes No

32) What has been your biggest problem living with diabetes?

33) Do you have a special question that you would like to discuss?

