Diabetes Questionnaire

INTERNATIONAL MEDICAL GROUP

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Please print

Name:		
Date of Birth:		
1. When were you told you had diabetes?		
2. Type of diabetes?		
3. Name, address and telephone number of present attending physician(s):		
4. Frequency of visits to a physician:		Date of last visit:
5. Frequency of blood sugars:	Date and result of last blood sugar:	Method used:
6. Do you test your urine for sugar?	How often?	Method used:

7. Treatment

Diet:

Insulin (type and dosage schedule):

Oral medication (type and dosage of all):

8. Has treatment changed during the last five years? ☐ Yes ☐ No

If yes, describe the changes

9. Have you ever had the following? Please provide dates, names, addresses and telephone number of attending physician(s).

Diabetic coma?	☐ Yes ☐ No	Eye trouble?	☐ Yes ☐ No
Insulin shock?	☐ Yes ☐ No	High blood pressure?	☐ Yes ☐ No
Heart disease?	☐ Yes ☐ No	Nerve disorder?	☐ Yes ☐ No
Kidney disease?	☐ Yes ☐ No	Any other complication?	☐ Yes ☐ No

10. Do other members of your family have diabetes? ☐ Yes ☐ No
If yes, whom?

Signature_____ Date_____

Updated 10/04