Avera Medical Group
Endocrinology & Diabetes
Sioux Falls

Plaza 3
1315 S. Cliff Ave., Suite 3000
Sioux Falls, SD 57105
605-322-7600 • Fax: 605-322-7601

Avera Medical Group Endocrinology & Diabetes Education Questionnaire

1. What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ I don't know

2. How long have you had diabetes? ______________________________

3. Have you received diabetes education with a nurse and dietitian in the past?
❑ No ❑ Yes If yes: Where: ______________________________
When: ______________________________
❑ Diabetes Nurse only
❑ Dietitian only
❑ Both Diabetes Nurse and Dietitian

4. Do you have a blood glucose meter? ❑ No ❑ Yes
If yes: Brand: ______________________________
How old is your meter? ______________________________
How often do you test? ______________________________
What time(s) of day do you test? ______________________________
Blood sugar range: ______________________________
Do you code your meter? ______________________________
Do you use your meter's control solution? ______________________________
Do you use alternate site testing? ______________________________

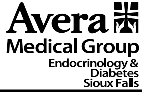
5. Are you taking diabetes medication? ❑ No ❑ Yes
Past diabetes medicines: ______________________________
Present diabetes medicine (dose and frequency): ______________________________

6. Do you take insulin? ❑ No ❑ Yes
If yes: Brand: ______________________________
Amount: ______________________________
Time of day: ______________________________
Where do you give your shots? (Check all the apply)
❑ Abdomen ❑ Arms ❑ Legs ❑ Buttocks
Do you rotate your injection sites? ❑ No ❑ Yes
Do you ever forget your doses?

7. What type of insulin delivery device do you use?
Pen: ______________________________
Vial and syringe: ______________________________
Pump: ______________________________
Brand: ______________________________
Basal Rate: ______________________________
Bolus Ratio: ______________________________
Sensitivity Factor: ______________________________
Do you ue the Bolus Wizard? ❑ No ❑ Yes

8. What types of insulin or diabetes pills have you used in the past?
____

9. Have you had any side effects or adverse reactions to any of your diabetes medications in the past?
❑ No ❑ Yes If yes, please list all side effects: ______________________________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10. Do you ever have low blood sugar reactions? ❏ No ❏ Yes
How often:______________________________
What time(s) of day do you get low: ______________________________
What does your blood sugar read when you feel low: ______________________________
Low blood sugar warning signs: ______________________________
Usual treatment: ______________________________
Do you carry quick acting sugar with you all the time? ❏ No ❏ Yes
Do you have a Glucagon kit? ❏ No ❏ Yes ❏ Don't know what this is

11. Have you ever been admitted to the hospital because of your diabetes? ❏ No ❏ Yes

12. Do you have any complications from your diabetes? ❏ No ❏ Yes (eyes, kidneys, neuropathy, etc.)
Please list all complications: ______________________________

13. Do you wear / carry a medical alert identification for diabetes? ❏ No ❏ Yes
Check all that apply: ❏ Bracelet ❏ Necklace ❏ Wallet Card

14. Do you check your feet? ❏ No ❏ Yes If yes, how often? ______________________________
Please list any foot problems: ______________________________
Any history of foot ulcers: ❏ No ❏ Yes

15. Daily schedule: Please write in the times for each item. If you don't have a set time, indicate a range.
Get up: ______________________________
Breakfast: ______________________________
Morning snack: ______________________________ Noon meal: ______________________________
Afternoon snack: ______________________________ Evening meal: ______________________________
Bedtime snack: ______________________________ Go to bed: ______________________________
Work hours (if you work outside the home): ______________________________

16. Do you get any regular scheduled exercise in addition to your job, housework, yardwork, etc.?
❏ No ❏ Yes If yes, what type of exercise: ______________________________
How often: ______________________________ How long: ______________________________

17. Have you had symptoms of elevated blood sugars recently? (Check all the apply):
❏ Hunger ❏ Thirst ❏ Dry Mouth ❏ Frequent urination ❏ Weight loss ❏ Blurred vision

18. Do you check your urine for ketones? ❏ No ❏ Yes ❏ Don't know what this is

19. Do you follow a diabetes meal plan? ❏ No ❏ Yes If yes, please indicate type:
❏ Carbohydrate counting ❏ Exchanges
❏ Constant carbohydrate ❏ No added sugar
❏ Other: ______________________________

20: Do you have dental disease? ❏ No ❏ Yes ❏ Date of last dental exam: ______________________________

21. Do you have eye disease? ❏ No ❏ Yes ❏ Date of last eye exam: ______________________________

22. What information do you need to help take better care of your diabetes? ______________________________

23. How well do you follow your diabetes treatment plan? Please circle: Not at all 1 2 3 4 5 Very well

Time: ______________ Date: ______________ Signature: ______________________________