SUMMIT PODIATRY GROUP, P.C.

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Questionnaire for Diabetic Patients

Patient's Name:_____ Date: _____

□ How long have you had diabetes? _____ Months _____ Years
□ Type of Diabetes (circle one):
Type 1, Type 2, Juvenile Onset, Adult Onset, Insulin Dependent, Brittle

□ How many times a day/week/month (circle one) do you check your blood sugar? _____
□ What was your last HgA1c? _____
□ What was your most recent blood sugar reading? ____ mg/dl
When was it taken? _____ (morning, afternoon, evening)

□ Are you taking medication for diabetes? Yes / No (circle one)

□ Do you wear Diabetic Shoes? Yes / No (circle one) Shoe Size _____

□ Do you have a history of foot sores that do not heal? Yes / No (circle one)

- If yes, which foot? Left / Right

□ Do you have any loss of sensation in your feet or toes, including burning, tingling, and/or numbness? Yes / No (circle one)

□ Do you have cramping in your legs or feet? Yes / No (circle one)

- If yes, when? (circle all that apply) Walking / At Rest / At Night / Sitting

□ Have you been hospitalized or had surgery/amputations for a condition related to your diabetes? Yes / No (circle one)

- If yes, please explain:_____

□ Do you see a diabetic specialist or endocrinologist? Yes / No (circle one)
If yes, please complete the following:

- Specialist's Name:_____
- Address:_____
- Date you were last seen _____Month _____Year

Thank you for completing this questionnaire. It is a helpful tool to provide you with excellent podiatric care!