Great Plains Diabetes Intake Form

Name _____ **Date** _____

Prevention	Date of Last Visit	Providers Name
Eye Exam		
Dental Exam		
Podiatrist/foot care		
Tobacco	YES/NO	Type/Amount:
Alcohol	YES/NO	Daily Weekly Monthly Rarely

Hypoglycemia

Can you tell when you are low? YES or NO

At what level? _____

Have you had any low blood sugars since your last visit that you were unable to treat yourself? YES or NO

Please mark problems you have had since your last visit:

( ) Vision Changes ( ) Headaches ( ) Too cold ( ) Too hot

( ) Skin Discoloration ( ) Excessive Dry Skin ( ) Chest Pain or Heaviness

( ) Shortness of Breath ( ) Dizziness ( ) Dizziness when Standing

( ) Numbness or tingling in hands/feet ( ) Muscle Cramps ( ) Diarrhea

( ) Problems with sexual functioning ( ) Loss of Urine ( ) Constipation

( ) Vaginal Discharge ( ) Abdominal Cramps ( ) Sleep Apnea

Other: _____

Do you feel you are under stress?
None Mild Moderate A Lot
In the past month, have you been bothered by feeling down, depressed, or hopeless? YES or NO
Have you had little pleasure or interest in doing things?
YES or NO

Any Medication Changes?

What information can we provide today?