

Insulin Pump Health Questionnaire

GENERAL INFORMATION

1. Name: _____ Date: _____ Age: _____ Race: _____ Sex: _____
2. Home phone: _____ work or cell: _____
3. Marital Status: Single Married Divorced Widowed
4. How many people live in your household? _____
5. Is there anyone who will help you with your diabetes care? Yes No
If yes, who? _____
6. Occupation: _____ Work hours: _____
7. Last grade of school completed? _____
8. Your Primary Physician's Name: _____
9. Your Diabetes Physician's Name: _____

DIABETES HISTORY

1. How long have you had diabetes? _____
2. What type of diabetes do you have? Type 1 Type 2 Gestational Don't know
3. In your own words, what is diabetes? _____

4. Have you ever been instructed on diabetes care? Yes No
If yes, when and where? _____

MEDICATION

1. Current insulin use:

Name of Insulin	Dosage	Time

2. Do you adjust your insulin? Yes No

If yes, describe: _____

3. Please list other medications that you take.

Medication	Dosage	Time

MEDICAL HISTORY

1. Do you have any of the following problems now? (Check and explain all that apply.)
 - Eye problems _____
 - Abnormal heart beat Chest pain Heart attack Open heart surgery Heart failure
 - Kidney problems _____

- GI problems_____
 - Numbness/pain_____
 - Sexual problems_____
 - Frequent infections_____
 - High cholesterol_____
 - High blood pressure_____
 - Other:_____
2. How often do you see a doctor about your diabetes?_____
 3. Have you been hospitalized for your diabetes or DKA? Yes No
If yes, how often?_____
 4. How would you describe your general health? Good Fair Poor
 5. Do you smoke?_____If yes, how much?_____
 6. Do you drink alcohol?_____If yes, amount and type:_____
 7. Do you wear a medical identification bracelet or necklace?_____

MONITORING

1. How often do you test your blood sugar? Rarely 1-2 times/day 3-4 times/day
 4-6 times/day 6 or more times/day
2. What type blood sugar monitor do you use?_____
3. Usual results:_____
4. Do you keep a record?_____
5. What blood sugar do you feel best at?_____
6. Do you test for urine ketones? Yes No
If yes, when do you test?_____
7. Do you have a Dawn Phenomenon? Don't know Yes No
8. What was your last A1c level?_____

HYPOGLYCEMIA

1. How often do you have a low blood sugar reaction requiring treatment?_____
Do you have symptoms of low blood sugar at 70?_____60?_____50?_____
How do you treat low blood sugars?_____
2. Have you ever had to be given glucagon? Yes No

EXERCISE

1. Do you exercise regularly? Yes No
Type of exercise(s) **Frequency** **Duration**

2. What, if anything, do you do different for your diabetes care on days that you exercise?_____

PSYCHOSOCIAL CONCERNS

1. How would you describe the level of stress in your life recently?
 very low low medium high very high
2. Any financial concerns related to diabetes care?_____

NUTRITION

1. Height:_____Present weight:_____Usual weight:_____Desired weight:_____
2. Have you ever received diet counseling? Yes No
If yes, describe:_____
3. Who does the cooking?_____
4. How many times during a week do you eat away from home?_____
5. How often is your meal away from home:_____

Cafeteria style? _____ Fast food? _____ Buffet? _____

Sit-down restaurant? _____ Other? _____

6. List any food allergies or intolerance _____
7. Do you have specific ethnic or cultural traditions (Examples: Jewish, Latin American, Asian, Vegetarian, etc)? _____

Usual Eating Habits (include amount and how prepared)		
Breakfast	Lunch	Dinner
Morning Snack	Afternoon Snack	Evening Snack

PUMP

1. What is your reason for considering a pump? _____

2. Describe what an insulin pump is and what it does: _____

3. Are you willing to keep detailed records of food intake, blood sugars, exercise, etc. to get regulated on the pump? _____

4. Where will you insert the infusion set? _____

5. Where will you wear the pump? _____

6. Do your significant others support the idea of you going on a pump? _____
7. How will your life be different on a pump? _____

8. How do you feel about wearing the pump all the time? _____

9. What are your fears/concerns of going on a pump? _____

10. What do you think will be the best thing about going on the pump? _____

11. What do you think will be the worst or most negative thing about going on the pump? _____

13. Have you decided on the type of pump you will use? Yes No
If yes, what type? _____

Diabetes Educator

Date

Medical Nutrition Therapy Questionnaire

Name: _____ Date of Birth: _____ Date: _____
Age: _____ Sex: _____ Occupation: _____ Email address: _____

Weight History:

Height _____ Present weight _____ Usual weight _____ Desired weight _____

Medical History:

Please check any of the following that you have or have had:

Shortness of breath Chest pain Irregular heart beat
 Abnormal stress test Angioplasty Stent
 Heart attack Open heart surgery Heart failure

List any other medical problems that you have or have had in the past: _____

List any medications that you take: _____

List any vitamins or herbs that you take: _____

List any food allergies that you have: _____

Do you smoke? Yes _____ No _____

Labs: (if known; OK to put "normal" if you have not had problems before)

Blood pressure: _____ Triglycerides: _____

Total cholesterol: _____ Blood sugar: _____

HDL: _____ LDL: _____

Other: _____

Diet History:

Have you been on any type diet before? Yes _____ No _____

If yes, what type: _____

How did it work for you? _____

Exercise:

Date of last stress test: _____

What are some types of exercise/activities that you do and how often: _____

What type of exercise restrictions do you have? _____

How would you describe your current exercise level?

None _____ Light _____ Moderate _____ Strenuous _____

Stress:

How would you describe your current stress level?

Low _____ Medium _____ High _____ Extremely high _____

What are some issues that are making you have more stress lately? _____

What are some things that you do to relieve stress? _____

Usual Eating Habits:

Please write down foods that you eat in a usual day:

First Meal (time): _____

Snack: _____

Second Meal (time): _____

Snack: _____

Third Meal (time): _____

Snack: _____

Comments:

What in particular do you feel like you need help with to improve your nutrition? _____