# diabeteslicenseplateTREE

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#

# Diabetes Follow Up Form

## Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Medications**

**This section for those who take *insulin by injection***

What basal insulin do you take?  Lantus  Levemir  NPH \_\_\_\_\_ units  other\_\_\_\_\_\_\_\_\_\_\_\_\_

 Time \_\_\_\_\_\_AM \_\_\_\_\_PM

 What bolus (meal/snack) insulin do you take?  Humalog  Novolog  Apidra  Regular  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use:   Syringes  Pens Type (s):  disposable pen  non disposable pen with cartridge

Where have you been giving insulin during the past few weeks? (please check all that apply)

  arms  legs  buttocks  abdomen  hips  other\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any problems since your last clinic visit when giving injections? (please check all that apply)

  bleeding  leakage  bruising  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which injection (s) are you most likely to miss?

  Basal Insulin (Lantus, Levemir, NPH)  Bolus (Mealtime) Insulin (Humalog, Novolog, Apidra, Regular)

How often do you forget/miss giving an insulin injection each day? (please check)

 1x/day  2x/day  3x /day  1-2X every other day  1-2x weekly  rarely

**This section for those who take *insulin via an insulin pump***

Which pump are you currently using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long have you had this pump? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which infusion set do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it a short canula?  no  yes

Who inserts the infusion set?  self  parent/significant other

How often do you change your infusion site?  every 1-3 days  every 4-5 days  every 6-7 days

Have you had a skin infection at the infusion set site since the last visit?  no  yes

If yes, how did you treat it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check the sites you use when inserting your infusion set? Abdomen  Waist  Hips  Buttocks  Thighs  Arms 

When would you suspend your pump? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Basal Rates: 12 AM \_\_\_\_\_ units/hr \_\_\_\_\_AM/PM \_\_\_\_\_ units/hr \_\_\_\_\_AM/PM \_\_\_\_\_ units/hr \_\_\_\_\_ AM/PM \_\_\_\_\_ unit/hr

Carb Insulin Ratio \_\_\_\_\_ Correction Factor \_\_\_\_\_ Target Range \_\_\_\_\_ Active Insulin Time \_\_\_\_\_

 I would like to make an appointment with the Diabetes Nurse Practitioner/Insulin Pump Specialist

* **Other Medical Problems**

Have you had any other medical problems since the last visit? [ ]  no [ ]  yes

 If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on any other new medications other than insulin since our last visit? [ ]  no  [ ]  yes

If yes, please list medication(s) & dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you allergic to any medication(s)? [ ]  no [ ] yes

If yes, please list medication(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Blood sugar testing/patterns**

What type(s) of blood glucose meter(s) do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill in the approximate time and grams of carbs eaten for each meal and snack consumed**.

 \* Clinic staff will complete averages, number of blood sugars, highs and lows

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Time** | **Carbs** | **\***Average | **\***Number | Number of Blood sugars >240 mg/dL | **\***Hypoglycemia values |
| **Breakfast** |  |  |  |  |  |  |
| **Snack** |  |  |  |  |  |  |
| **Lunch** |  |  |  |  |  |  |
| **Afternoon Snack** |  |  |  |  |  |  |
| **Supper** |  |  |  |  |  |  |
| **Bedtime Snack** |  |  |  |  |  |  |
| **3 am** |  |  |  |  |  |  |

* **Low blood sugar**

How low does your blood sugar have to be before you have symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel different when your blood sugar is low? [ ] no [ ]  yes (check your usual symptoms)

[ ]  sweaty [ ]  shaky [ ]  hungry [ ]  weak [ ]  pale [ ]  dizzy [ ]  nervous [ ]  headache [ ]  irritable [ ]  unusual behavior [ ]  other

Since your last clinic visit, have you had a low blood sugar that you were unable to treat on your own? [ ]  no [ ]  yes

If yes, how many times has this occurred? \_\_\_\_\_\_\_\_ Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you: [ ]  very confused [ ]  unconscious [ ] had a seizure

If yes, approximately how many times has this occurred? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you usually use to treat a low blood sugar? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you have food/tablets available to treat a low blood sugar? [ ]  almost always [ ]  sometimes [ ]  never

Do you have a glucagon emergency kit? [ ]  no [ ]  yes Has it expired? \_\_\_\_\_\_\_\_\_\_

* **High Blood Sugar**

How do you feel when your blood sugar is high?

 [ ]  more thirsty [ ]  more frequent urination [ ]  eating more [ ]  weight loss

 [ ]  bed wetting [ ]  more frequent urination at night [ ]  nauseated [ ]  constipation

 [ ]  blurry vision [ ]  belly pain [ ]  leg cramps [ ]  other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you check for ketones?

 [ ]  no [ ]  yes If so, when do you check? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized, or in the Emergency Room, since your last clinic visit?

 [ ]  no [ ]  yes If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **Self Management Information**

**Nutrition**

Do you use a meal planning strategy? [ ]  no [ ]  yes

 If yes, what do you use? (please check) [ ]  consistent carbohydrate intake [ ]  Insulin: carb ratio

 [ ]  other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your current meal plan? [ ]  no [ ]  yes If no, is it: [ ]  too much [ ]  not enough

How often do you eat meals outside of the home? [ ]  0-1x/week [ ]  2-3x/week [ ]  >3x/week

What do you drink? Water [ ]  how many glasses/day \_\_\_\_\_

(*Check all that apply*) Soda [ ]  how many glasses/day \_\_\_\_\_

 Diet soda [ ]  how many glasses/day \_\_\_\_\_

 Sports drinks [ ]  how many glasses/day \_\_\_\_\_

 Juice [ ]  how many glasses/day \_\_\_\_\_

[ ]  skim [ ] 1% [ ]  2% [ ]  whole Milk [ ]  how many glasses/day \_\_\_\_\_

Do you use any alternative supplements to treat your child’s diabetes (herbs, proteins, powders, chromium)?

[ ]  no [ ]  yes If yes, what\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need to speak with a dietician today? [ ]  no [ ]  yes

If yes, please state why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activity**

Do you exercise? [ ]  no [ ]  yes

Type of activity (unplanned or organized)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Frequency: \_\_\_\_\_times per week How long does the activity usually last? \_\_\_\_\_minutes

How do you prevent low blood sugar(s) during exercise? [ ]  more food  [ ]  less insulin

If you are in school, do you have P.E./gym class? [ ]  no [ ]  yes

If yes, how many times a week? \_\_\_\_\_ Is gym class: [ ]  before lunch [ ]  after lunch

Do you eat an extra snack before P.E. /gym class? [ ]  no [ ]  yes If yes, list what it is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Teamwork**

Please indicate what percentage out of 100 (100% = all the time) does the parent/significant other and person with diabetes participate in their diabetes management.

|  |  |  |
| --- | --- | --- |
|  | Person with diabetes(%) | Parent /significant other(%) |
| Injections |  |  |
| Glucose monitoring |  |  |
| Insulin Adjustments |  |  |
| Food decisions |  |  |
| Activity management |  |  |
| Other |  |  |

*Comments are welcomed*:

**Safety**

Do you have a medical ID bracelet/necklace? [ ]  no [ ]  yes

If yes, are you wearing it now? [ ] no [ ] yes

Have you had your flu shot this year?  **[ ]** no [ ]  yes- When? \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ (month/Year)

* **Learning/Social Environment and Coping**

**School Issues**

For younger children: does your child attend preschool or in day care?  [ ]  no [ ]  yes

For children/adolescents who are in school: What grade are you in? \_\_\_\_\_\_\_\_\_ What year will you graduate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How are you getting along in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grades: \_\_\_\_\_\_\_\_\_\_\_\_

Recent change to a different school? [ ]  no [ ]  yes

Friendship/peer problems: [ ]  no [ ]  yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How well does the school staff help to manage diabetes care at school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Life Changes**

Are there changes in your situation since your last clinic visit?

[ ]  changed or lost job? [ ]  changed or lost insurance? [ ]  transportation problems?

[ ]  obtained or lost Medicaid/CSHS? [ ]  changes in who lives in the home?

**Stress**

Are you worried about anything that affects your diabetes care? [ ]  no [ ]  yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to make an appointment with our health- psychologist?  [ ]  no  [ ]  yes

* **Health Maintenance**

**Weight**

[ ]  No change since my last visit [ ]  I have gained \_\_\_\_\_ lbs. [ ]  I have lost \_\_\_\_\_ lbs.

[ ]  My dress/pants size has changed from \_\_\_\_\_\_ to \_\_\_\_\_\_

**Smoking/Drinking**

Cigarettes: [ ]  no [ ]  yes If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cigars: [ ]  no [ ]  yes If yes, how many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take any type of illegal “drugs”? [ ]  no [ ]  yes

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink alcohol [ ]  no [ ]  yes how many drinks per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pre-pregnancy counseling (premenopausal female patients with reproductive potential only)**

Are you sexually active? [ ]  no [ ]  yes Do you use protection? [ ]  no [ ]  yes

**Eye Care**

Have you had a dilated eye exam since your last visit?

 [ ]  no [ ]  yes date of exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Care**

Have you had a dental exam since your last visit?

 [ ]  no [ ]  yes date of exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Foot Care**

Have you had a foot exam by the podiatrist since your last visit?

 [ ]  no [ ]  yes date of exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescriptions**

Do you need refills on any of your prescriptions? [ ]  no [ ]  yes  **If yes, please fill out our Rx request form**

**Current Primary Care Providers** (please list):

**Contact Phone Numbers**: Work ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **alternate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Form completed by**: [ ]  Self [ ]  Parent/ Significant Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Verified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD/ARNP**  **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**