# 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**