

Western Canadian Insulin Pump Centre
410-1033 Davie Street
Vancouver, BC V6E 1M7

Please complete this new patient questionnaire and return it prior to your first visit.
Fax to: 604 602 9008 or email to: marinac@insulinpumpcentre.com

Name : _____

Date of Birth : _____

Occupation: _____

Diabetes Diagnosed : _____ weeks , _____ months, _____ years, _____ not sure

Type 1 _____ Type 2 _____

How was diabetes diagnosed? Check as many symptoms as you had.

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> excessive thirst | <input type="checkbox"/> excessive urination | <input type="checkbox"/> weight loss |
| <input type="checkbox"/> visual blurring | <input type="checkbox"/> black outs | <input type="checkbox"/> hypoglycemia |
| <input type="checkbox"/> routine blood test | <input type="checkbox"/> recent skin infections | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> excessive hunger | <input type="checkbox"/> other | <input type="checkbox"/> no symptoms |

How was your diabetes treated initially? Check as many as appropriate.

- | | |
|--|----------------------------------|
| <input type="checkbox"/> hospitalization | <input type="checkbox"/> pills |
| <input type="checkbox"/> diet | <input type="checkbox"/> insulin |

Have you ever attended a diabetes teaching program ? Yes_ No _

Where did you attend the teaching program? _____

When was the last time you attended a diabetes teaching program? _____(m/y)

What therapy do you follow for your diabetes ?

- | | |
|--|-----------------|
| <input type="checkbox"/> Diet, number of calories _____ | |
| <input type="checkbox"/> Oral agents (pills), type _____ | Dosage _____ |
| <input type="checkbox"/> Insulin, type _____ | Human _____ |
| | Beef/Pork _____ |

Dosage: morning _____, noon _____, supper _____, bed _____

Delivery System: Syringe _ Pen _ Pump _

Do you perform home blood testing? Yes No

How often do you test?

- more than 4x /day daily
- 4x/day weekly
- 3x/day other
- 2x/day

What was your last Hgb A1C : _____ Date of last HgbA1C : _____

Family history of DM ? Yes No Who? : _____

Number of pregnancies? _____

Weights of children : _____

Who is your Ophthalmologist?(eye doctor) : _____

When did you last visit your ophthalmologist : _____

Have you had:

- | | | | |
|--------------------|------------------------------|-----------------------------|---------------|
| Cataracts | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Cataract surgery | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Laser therapy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Vitrectomy | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Retinal Detachmnet | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Glaucoma | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |

Have you ever had a heart attack? Yes No Date(s): _____

Have you ever had:

- | | | | |
|------------------------|------------------------------|-----------------------------|---------------|
| Stress test | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Thallium stress test | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Coronary angiography | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Angioplasty | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Coronary artery bypass | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |
| Stroke | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Date(s) _____ |

Do you have chest discomfort with:

exercise	Yes _	No _
after eating	Yes _	No _
if you are upset	Yes _	No _

If you have chest discomfort , how often do you get it?

Daily	Yes _	No _
Weekly	Yes _	No _
Monthly	Yes _	No _
Yearly	Yes _	No _

Where is the location of the pain? _____

Does it go anywhere? _____

What makes it better? _____

What is the longest that it has lasted? _____

Do you get short of breath:

walking a block	Yes _	No _
walking up 1 flight of stairs	Yes _	No _
walking up 2 flight of stairs	Yes _	No _
walking quickly	Yes _	No _
running	Yes _	No _
rarely get short of breath	Yes _	No _

Do you ever wake up a night short of breath? Yes _ No _

How many pillows do you use to sleep at night? _____

Do your ankles swell? Yes _ No _

Have you noticed your heart racing? Yes _ No _

Do you ever have to stop walking because of leg pains? Yes _ No _

If so, which leg(s) is affected? Left _ Right _ Both _

How far can you walk?

1 block	Yes _	No _
5 blocks	Yes _	No _
_ mile	Yes _	No _
1 mile	Yes _	No _
more	Yes _	No _

Have you ever had vascular surgery? Yes _ No _

If yes, list days and operations: _____

Do your legs ache at night? Yes _ No _

Do you get dizzy when you stand up quickly? Yes _ No _

Do you have difficulty obtaining erections? Yes _ No _

If so, how long has this been a problem? _____

Do you sweat profusely immediately after a meal? Yes _ No _

Do you have diarrhea at night time? Yes _ No _

Do you feel "bloated" after meals? Yes _ No _

Do you have a history of high blood pressure? Yes _ No _

Have you ever been told of having protein in your urine? Yes _ No _ Date _____
(if "yes")

Have you ever had a stroke? Yes _ No _

Have you ever had weakness on one side of your body? Yes _ No _

Have you ever lost sensation on one side of your body? Yes _ No _

Have you ever lost your vision? Yes _ No _

Have you ever had hypoglycemia(low blood sugar)? Yes _ No _

Are you aware before hypoglycemia occurs? Yes _ No _

What symptoms make you aware of hypoglycemia?

Sweating	Yes _ No _	Fast heart beat	Yes _ No _
Anxiety	Yes _ No _	Change in moods	Yes _ No _

Blurred vision Yes _ No _ Numbness around the lips Yes _ No _

How many times in the last 12 months have you :

been unconscious requiring medical help? _____

needed help with a reaction? _____

had a reaction not needing help? _____

Please list your medications and dosage: _____

Please list the number of days and reasons you have been in hospital overnight (surgery, testing, illness, etc.) _____

Do you have :

dry eyes Yes _ No _ bulging eyes Yes _ No _

nosebleeds Yes _ No _ allergies Yes _ No _

hx. of thyroid problems Yes _ No _ heat intolerance Yes _ No _

cold intolerance Yes _ No _ hx. of pneumonia Yes _ No _

a smoking history Yes _ No _ hx. of rectal bleeding Yes _ No _

 how many cigarettes/ day ? _____ hx. of arthritis Yes _ No _

do you drink alcohol? Yes _ No _

 how much per week? _____

have you ever coughed up blood? Yes _ No _

hx. of ulcers? Yes _ No _

hx. black bowel movements? Yes _ No _

hx. of urinary infections? Yes _ No _

history of menstrual problems? Yes _ No _

history of emotional problems? Yes _ No _

Are you married? Yes _ No _

Do you have family or marital stress? Yes _ No _

Do you have any work related stress? Yes _ No _

Please give your diary to the clinic's secretary to fill out your average blood values.

	Morning	noon	supper	bed
average	_____	_____	_____	_____
standard deviation	_____	_____	_____	_____

Today's date _____