Diabetes mellitus questionnaire – Attending physician

Patient's name

Date of birth DD / MM / YYYY

QUESTIONNAIRE

1. When was diabetes first diagnosed? DD / MM / YYYY
2. Please confirm the type of diabetes
   a) Type 1 diabetes mellitus ☐
   b) Type 2 diabetes mellitus ☐
   c) Other(Please specify) ☐
3. Regarding your patient's treatment:
   a) Is oral medication prescribed? Yes ☐ No ☐
   If Yes, please name the medication.
   b) Is insulin prescribed? Yes ☐ No ☐
   If Yes, please state the type and dosage, including number of times used daily.
4. Regarding the management of diabetes mellitus:
   a) How well does the patient control their diabetes mellitus?
   b) Please provide any plasma glucose results, noting whether fasting or non-fasting, in the past 12 months.
   c) Please provide any urinalysis results in the past 12 months.

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DIABETES MELLITUS (CONTINUED)

d) Please provide any HbA1c results in the past 12 months.

e) How often does the patient attend your practice or clinic for monitoring?

f) When was your last consultation?

g) Please provide the name and address of any other clinic or doctor supervising treatment.

5. Since treatment began, has the patient ever experienced episodes of hypoglycaemia requiring hospitalization, or admission to hospital due to diabetic coma, ketoacidosis or any condition related to a diabetes?
If yes, please provide full details, including dates.

Yes ☐ No ☐

6. Has the patient ever had any of the following?

a) Proteinuria or albuminuria	Yes ☐	No ☐
b) Nephropathy	Yes ☐	No ☐
c) Retinopathy	Yes ☐	No ☐
d) Neuropathy	Yes ☐	No ☐
e) Hypertension	Yes ☐	No ☐
f) Ischaemic heart disease	Yes ☐	No ☐
g) Peripheral vascular disease	Yes ☐	No ☐

If Yes, please provide full details.

DIABETES MELLITUS (CONTINUED)

7. Has the patient ever undergone any of the following investigations?

   a) Resting and or exercise electrocardiogram Yes ☐ No ☐

   b) Blood tests for lipids or renal functions? Yes ☐ No ☐

   c) Blood pressure and BMI readings? Yes ☐ No ☐

   If Yes, please provide full details.

8. Please provide full details of any time off work or any inability to perform normal daily activities due to Diabetes

9. Which other disorders or risk factors (eg. smoking) are present that may influence the prognosis?

DECLARATION

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

Signature ✗ Date DD / MM / YYYY

Printed name, qualification or clinic stamp

Please return the completed form to:
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