BMedicalConditions

Severe Hypoglycemia in older Adults Protocol CRF
Medical Conditions Form

PtID:_____
Initials:_____

Record any medical condition that is either present now, a chronic disease, or a prior condition that could impact the participant's future health (e.g. prior MI or stroke). Update as indicated.

Condition MCLLTReal	**Date of Diagnosis or occurrence (if unknown, estimate month and year)**	**Treatment** **MedCondTrt**
		☐ Medication ☐ Surgery ☐ Medication and Surgery ☐ Dietary Management ☐ Unknown ☐ Other _____
		☐ Medication ☐ Surgery ☐ Medication and Surgery ☐ Dietary Management ☐ Unknown ☐ Other _____
		☐ Medication ☐ Surgery ☐ Medication and Surgery ☐ Dietary Management ☐ Unknown ☐ Other _____
		☐ Medication ☐ Surgery ☐ Medication and Surgery ☐ Dietary Management ☐ Unknown ☐ Other _____