# Diabetes Patient Questionnaire

## Personal Information

Name: _____ Date: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Email (optional): _____

Primary Care Provider: _____

Endocrinologist (if applicable): _____

## Diabetes History & Management

1. How long have you had diabetes? _____

2. Have you attended diabetes education classes before? ☐ Yes ☐ No

   - If yes, when and where? _____

3. Do you have a family history of diabetes? ☐ Yes ☐ No

   - If yes, indicate relation: _____

## Blood Sugar Monitoring

4. Do you check your blood sugar at home? ☐ Yes ☐ No

   - If no, why not? _____

5. How often do you test per day? ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5+

6. When do you test? (Check all that apply):

   ☐ Before meals ☐ After meals ☐ At bedtime ☐ Other: _____

7. Do you use a continuous glucose monitor (CGM)? ☐ Yes ☐ No

## Blood Sugar Issues

8. Do you experience low blood sugar? ☐ Yes ☐ No ☐ Unsure

   - If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

   - When does it usually occur? (Check all that apply):

     ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

   - How do you treat it? _____

9. Have you ever lost consciousness due to low blood sugar? ☐ Yes ☐ No

10. Do you experience high blood sugar? ☐ Yes ☐ No ☐ Unsure

    - If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____

    - When does it usually occur? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

    - How do you treat it? _____

## Medical History & Lifestyle

11. Do you have any other health conditions? (Check all that apply):

    ☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol

    ☐ Glaucoma ☐ Stroke ☐ Retinopathy

    ☐ Kidney Disease ☐ Asthma ☐ Neuropathy

    ☐ Thyroid Issues ☐ Dental Problems ☐ Other: _____

12. Do you take diabetes medication? ☐ Yes ☐ No

13. Do you use insulin? ☐ Yes ☐ No

14. Do you use an insulin pump? ☐ Yes ☐ No

15. How often do you see your doctor for diabetes care?

    ☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐ Annually ☐ Other: ____

16. When was your last eye exam? Date: _____

17. Do you live alone? ☐ Yes ☐ No - If no, who do you live with? _____

18. Do you smoke? ☐ Never ☐ Former Smoker ☐ Current Smoker

19. Do you drink alcohol? ☐ No ☐ Occasionally ☐ Regularly

- What type? ☐ Beer ☐ Wine ☐ Liquor - Frequency: _____

## Lifestyle & Emotional Well-being

20. How does having diabetes make you feel? (Check all that apply):

☐ Angry ☐ Anxious ☐ Confused ☐ Sad ☐ Motivated to eat better

☐ Like I can't live the way I want ☐ Like I am a sick person

21. Do you experience stress?

☐ Yes ☐ No

- If yes, how do you manage stress? _____

22. Do you feel depressed?

☐ No ☐ Rarely ☐ Sometimes ☐ Often

- Would you like support for emotional well-being? ☐ Yes ☐ No

## Exercise & Diet

23. Do you exercise?

☐ Yes ☐ No

- If yes, what type? ☐ Walking ☐ Running ☐ Cycling ☐ Gym ☐ Other: _____

- How often? ☐ Daily ☐ 1-2x/week ☐ 3-4x/week ☐ 5+ times/week

- Any limitations on exercise? ☐ Yes ☐ No - If yes, describe: _____

24. Have you received dietary guidance?

☐ Yes ☐ No

25. Do you follow a meal plan?

☐ Yes ☐ No - If yes, how often?

☐ 0-25% of the time ☐ 25-50% ☐ 50-75% ☐ 75-100%

26. Do you follow any dietary restrictions?

☐ No ☐ Yes (Check all that apply):

☐ Vegetarian ☐ Vegan ☐ Low-Carb ☐ Low-Fat ☐ Low-Salt ☐ Other: _____

27. Do you take vitamins or supplements?

☐ Yes ☐ No - If yes, which ones? _____

28. What eating concerns do you have? _____

29. What would you like to learn more about? (Check all that apply):

☐ Weight Loss ☐ Diet ☐ Exercise ☐ Reading Food Labels ☐ Other: _____

## Goals & Program Expectations

30. What do you hope to achieve with this program? (Check all that apply):

☐ Improve blood sugar control ☐ Eat healthier ☐ Lose weight

☐ Increase physical activity ☐ Lower cholesterol ☐ Lower blood pressure

☐ Other: _____

## Feedback (Optional)

31. How long did this questionnaire take to complete? _____ minutes

32. Was the questionnaire easy to understand?

☐ Yes ☐ No

33. Do you feel there was enough space to write answers?

☐ Yes ☐ No

34. Was the questionnaire too long?

☐ Yes ☐ No

35. Additional comments or suggestions: _____

Thank you for completing this questionnaire!