

IN PARTNERSHIP WITH



SCREENING TOOL FOR DIABETES

PATIENT DETAILS PATIENT NUMBER: _ _ _ _ _ AGE:_____ GENDER Male Female Pregnant **TESTS** Daibetes:_____ Glucose: HBA1C:_____ Blood Preasure:_____ Cholesterol:_____ BMI: _____. Questions Have you ever been YES NO diagnosed with diabetes? Does your family have any history of diabetes? YES NO

