Grossman Podiatry Center
family footcare since 1932

Questionnaire for Patients with Diabetes

Patient Name: _____ Date: _____

- How long have you had diabetes? _____Months _____Years
- How many times a day/week/month (circle one) do you check your blood sugar? _____
- Who checks your blood sugar? (circle one) You / Your doctor / Someone else
- What is your blood sugar normally?_____mg/dl
- What was your most recent blood sugar reading? _____ mg/dl
  When was it taken? _____ (morning, afternoon, evening)
- Are you taking medication for diabetes? Yes / No (circle one)
- If yes, name of medication_____
  Dose _____
  - If you are on insulin, how long have you been taking insulin?
    _____Weeks _____Months _____Years
  - Name of insulin used _____ Dosage _____
- Do you have a history of foot sores that do not heal? Yes / No (circle one) If yes, which foot? Left / Right
- Do you have any loss of sensation in your feet or toes, including burning, tingling, and/or numbness? Yes / No (circle one)
- Do you have cramping in your legs or feet? Yes / No (circle one)
  - If yes, when? (circle all that apply) Walking / At Rest / At Night / Sitting
- Have you been hospitalized or had surgery in the last five years for a condition related to your diabetes? Yes / No (circle one)
  - If yes, please explain: _____
- Do you have a primary care physician? Yes / No (circle one)
  If yes, please complete the following:
  - Physician's Name:_____
  - Address_____
    _____
  - Date you were last seen _____Month _____Year
- Do you see a diabetic specialist? Yes / No
  If yes, please complete the following:
  - Specialist's Name:_____
  - Address_____
    _____
  - Date you were last seen _____Month _____Year

Thank you for completing this questionnaire. It is a helpful tool to provide you with excellent podiatric care!