Diabetes questionnaire - Physician

Full name of applicant:				
Application number:				
1. When was the diabetes diagnosed?				
2. Please confirm the type of diabetes a) Diabetes mellitus Type I b) Diabetes mellitus Type II c) Gestational diabetes d) Other If other please specify:				
3. What treatment has been prescribed? a) Diet only b) Oral hypoglycaemics If YES, please state drug and dosa	ge.	Yes 🗌 Yes 🗍	No 🗌 No 🗍	
c) Insulin If YES, please state type and dosa	ge.	Yes 🗌	No 🗌	
4. How well does the patient control his/her condition?				
5. If you are the attending physician, does the patient also attend a specialist diabetic clinic? If so, please provide the name and address of clinic, and date of last known attendance.				
6. Have there been any episodes of hypoglycaemia requiring intravenous glucose, or hospital admission due to diabetic coma, ketoacidosis, or any other diabetic related condition? If so, please provide details.				
7. Please provide details of any blood sug fasting.	gar levels taken within the last 12 months, includi	ng wheth	er fasting or non-	
8. Please provide results of any glycosyla	ted haemoglobin levels within the last two years.			
9. Has the patient undergone any of the f a) Urine tests for microalbuminuria b) ECG, stress test c) Blood tests for lipids, RFT´s etc If yes to any of the above, please p	a	Yes	No	

 10. Is there evidence of any of the following? a) Retinopathy b) Nephropathy c) Neuropathy d) Ischaemic heart disease e) Peripheral vascular disease If YES to any of the above, please provide complete details. 	Yes	No
11. Please provide details of any other factor or condition which may influence the prognes moking, hypertension, hyperlipidaemia, etc.	osis of the	diabetes, e.g.
Signature		
Date		
Please print name and add clinic stamp		