

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

Yes No

b) Oral hypoglycaemics

Yes No

If YES, please state drug and dosage.

c) Insulin

Yes No

If YES, please state type and dosage.

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 sugar levels taken within the last 12 months, including whether fasting or non-fasting.

8. Please provide results of any glycosylated haemoglobin levels within the last two years.

9. Has the patient undergone any of the following investigations?

a) Urine tests for microalbuminuria

Yes No

b) ECG, stress test

Yes No

c) Blood tests for lipids, RFT's etc.

Yes No

If yes to any of the above, please provide results and dates tested.

10. Is there evidence of any of the following?

a) Retinopathy

Yes No

b) Nephropathy

Yes No

c) Neuropathy

Yes No

d) Ischaemic heart disease

Yes No

e) Peripheral vascular disease

Yes No

If YES to any of the above, please provide complete details.

11. Please provide details of any other factor or condition which may influence the prognosis of the diabetes, e.g. smoking, hypertension, hyperlipidaemia, etc.

Signature

Date

Please print name and add clinic stamp