



On the life of: _____ Date of Birth: _____

Occupation _____

1) When was diabetes first diagnosed? _____

2) Provide name and address of doctor presently consulting.

Name _____

Address _____

Date _____ Include date of last visit _____

3) Indicate (a) Method of treatment Insulin Oral Diet

(b) Type of medication _____

(c) Daily dosage — include caloric and carbohydrate intake _____

Answer the following questions "Yes" or "No" providing details, names and addresses of physicians consulted if the answer is in the affirmative.

4) Have there been any changes in medication or treatment within the last two years? Yes No

5) Has there been any weight gain or loss in the last two years? Yes No
If "yes", indicate number of pounds lost or gained Loss: _____ lbs. Gain: _____ lbs.

6) Have you had any (a) insulin reactions? Yes No

(b) diabetic comas? Yes No

(c) keto-acidosis? Yes No

7) Have you had any infections such as boils, abscessed teeth, gums, etc.?. Yes No

8) Have you had any eye problems (blurring of vision, cataracts, etc.)? Yes No

9) Have you had any heart or circulatory problems (chest pains, high blood pressure, etc.)? Yes No

10) Have you had any kidney trouble? Yes No

11) Have you had any tingling or numbness in the lower limbs? Yes No

12) Have you ever had any pains in the legs? Yes No

13) Have you ever had any electrocardiograms, chest or kidney x-rays or other special tests? Yes No

14) Are there any other details not covered by the above questions?

Signed at: _____ Witness: _____

Date: _____ Signature: _____