

Diabetes Mellitus Questionnaire – This questionnaire should be completed by the medical attendant

Full name of the person to be assured: _____

Date of Birth & Age: _____ Patient since: _____

Please provide all the following information regarding your patient's diabetes.

Exact date and type of diabetes (e.g. type 2 DM) _____

When the diabetes was first diagnosed? _____

HbA1c (glycosylated haemoglobin A1c) control:

Date	HbA1c Value	Laboratory Reference Range
_____	_____	_____
_____	_____	_____

Date and result of the last urine sample:

Date	Proteinuria
_____	<input type="checkbox"/> Yes
	If yes, amount: _____
_____	<input type="checkbox"/> No
_____	<input type="checkbox"/> Yes
	If yes, amount: _____
_____	<input type="checkbox"/> No

Does your patient suffer from nephropathy? Yes No

Does your patient suffer from hypertension? Yes No

If so, please provide last blood pressure values and state if she / he is currently under treatment.

Date	BP value	Under treatment
_____	_____	_____
_____	_____	_____

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Does your patient suffer from any kind of the following complications?

- retinopathy
- proliferative retinopathy
- retinal detachment
- loss of visual acuity (degree)
- blindness
- neuropathy associated with motor involvement and disabling symptoms
- gangrene
- amputation
- cardiovascular autonomic neuropathy
- ischaemic heart disease
- myocardial infarction
- positive treadmill exercise test
- cerebrovascular disease
- stroke, TIA
- Any other complications? _____

Does your patient smoke? Yes No

Remarks/observations _____

Date, signature and stamp of the medical attendant