TANDEM® DIABETES CARE

HEALTH AND PRODUCT QUESTIONNAIRE

This form can also be filled out online at www.tandemdiabetes.com

FAX completed signed form to:
(855) 875-4648

PATIENT'S NAME (FIRST MIDDLE LAST)			DATE OF BIRTH (MM/DD/YYYY)
			/ /
HEIGHT _____feet _____inches	WEIGHT _____lbs.	DATE OF DIAGNOSIS (MM/YYYY) /	GENDER ☐ Male ☐ Female

TELL US ABOUT YOUR DIABETES

DIABETES TYPE		NUMBER OF BLOOD GLUCOSE TESTS PER DAY	CURRENT INSULIN
☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: _____			☐ Novolog® ☐ Humalog® ☐ Apidra® ☐ Lantus® ☐ Other: _____
HIGHEST AND LOWEST BLOOD GLUCOSE VALUE (WITHIN THE LAST 3 MONTHS) _____(High) _____(Low)		LATEST HbA1c – RESULT _____ . _____%	DATE (MM/DD/YYYY) / /
ARE YOU CURRENTLY PREGNANT? ☐ Yes ☐ No	ARE YOU PLANNING A PREGNANCY? ☐ Yes ☐ No	PRIOR HbA1c – RESULT _____ . _____%	DATE (MM/DD/YYYY) / /

CURRENT DIABETES THERAPY: ☐ Insulin Pump ☐ Multiple Daily Injections ☐ Other: _____

⬇ IF PUMP USER ⬇		⬇ IF MULTIPLE DAILY INJECTION USER ⬇
MANUFACTURER	MODEL	NUMBER OF INJECTIONS PER DAY
DATE OF PURCHASE (MM/YYYY) /	DID CURRENT INSURANCE PAY FOR THIS PUMP? ☐ Yes ☐ No	NUMBER OF UNITS PER DAY

REASON FOR UPGRADING YOUR PUMP (INCLUDING ANY PUMP MALFUNCTIONS)

PLEASE CHECK YES OR NO TO THE FOLLOWING

⬇ HAS YOUR PRESCRIBING HEALTHCARE PROVIDER DIAGNOSED YOU FOR ANY OF THE FOLLOWING ⬇

1. Diabetic Ketoacidosis (dangerous condition with dehydration, insulin deficit and high level of ketones present in the blood/urine) ..... ☐ Yes ☐ No
2. Hyperglycemia (a higher than normal level of glucose in the blood) ..... ☐ Yes ☐ No
3. Hypoglycemic Unawareness (inability to sense when your blood sugar is low) ..... ☐ Yes ☐ No
4. Nocturnal Hypoglycemia (low blood glucose readings while sleeping) ..... ☐ Yes ☐ No
5. Recurrent Hypoglycemia (frequent daytime lows) ..... ☐ Yes ☐ No
   - ▸ Any assistance with low blood glucose within the last 2 years? ..... ☐ Yes ☐ No
   - ▸ If yes, please describe: _____
6. Dawn Phenomenon (wake up with an increase in glucose readings) ..... ☐ Yes ☐ No
7. Retinopathy (eye disease) ..... ☐ Yes ☐ No
8. Gastroparesis (slowed stomach emptying) ..... ☐ Yes ☐ No
9. Nephropathy (kidney problem) ..... ☐ Yes ☐ No
10. Post-renal Transplant? ..... ☐ Yes ☐ No
11. Neuropathy (pain, numbness, tingling or burning in hands or feet, increased heart rate, low blood pressure, delayed digestion, erectile dysfunction) ... ☐ Yes ☐ No
12. Cardiovascular Disease (heart attack or stroke) ..... ☐ Yes ☐ No

⬇ IN THE PAST 2 YEARS, DID YOU HAVE DIABETES RELATED... ⬇

13. Hospitalization? ..... ☐ Yes ☐ No
    - ▸ If yes, please describe: _____
14. Previous pump training/education? ..... ☐ Yes ☐ No
    - ▸ If yes, please describe: _____
15. Weight loss? ..... ☐ Yes ☐ No
    - ▸ If yes, please describe: _____

INFORMATION COMPLETED BY

PRINTED NAME (PRINT FULL NAME)	SIGNATURE	DATE (MM/DD/YYYY)
	X	/ /