



PATIENT'S NAME (FIRST MIDDLE LAST)			DATE OF BIRTH (MM/DD/YYYY)
HEIGHT _____ feet _____ inches			WEIGHT _____ lbs.
DATE OF DIAGNOSIS (MM/YYYY)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	

TELL US ABOUT YOUR DIABETES	DIABETES TYPE <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Other: _____		NUMBER OF BLOOD GLUCOSE TESTS PER DAY	CURRENT INSULIN	
	HIGHEST AND LOWEST BLOOD GLUCOSE VALUE (WITHIN THE LAST THREE MONTHS) (High) _____ (Low) _____		LATEST HbA1c - RESULT _____ %	DATE (MM/DD/YYYY) / /	
	ARE YOU CURRENTLY PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No	ARE YOU PLANNING A PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No	PRIOR HbA1c - RESULT _____ %	DATE (MM/DD/YYYY) / /	
	CURRENT DIABETES THERAPY: <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Multiple Daily Injections <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Hyperglycemia (a higher-than-normal level of glucose in the blood)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Hypoglycemic unawareness (inability to sense when your blood sugar is low)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Nocturnal hypoglycemia (low blood glucose readings while sleeping).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Recurrent hypoglycemia (frequent daytime lows)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	▶ Any assistance with low blood glucose within the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	▶ If yes, please describe: _____	
	6. Dawn phenomenon (wake up with an increase in glucose readings).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	7. Retinopathy (eye disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	8. Gastroparesis (slowed stomach emptying)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	9. Nephropathy (kidney problem).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	10. Post-renal transplant?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
	11. Neuropathy (pain, numbness, tingling or burning in hands or feet, increased heart rate, low blood pressure, delayed digestion, erectile dysfunction) ...	<input type="checkbox"/> Yes <input type="checkbox"/> No
	12. Cardiovascular disease (heart attack or stroke).....	<input type="checkbox"/> Yes <input type="checkbox"/> No
↓ IN THE PAST TWO YEARS, DID YOU HAVE DIABETES-RELATED... ↓		
13. Hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ If yes, please describe: _____		
14. Pump training/education?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ If yes, please describe: _____		
15. Weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ If yes, please describe: _____		

INFORMATION COMPLETED BY

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