

**Additional Intake Form for New Diabetic Patients:**

Have you currently been diagnosed with one of the following (please circle):

Pre-Diabetes      Type 1 Diabetes Mellitus      Type 2 Diabetes Mellitus

Gestational Diabetes      Other form of Diabetes \_\_\_\_\_

When were you diagnosed with Diabetes?: \_\_\_\_\_

What medications do you take to control your Diabetes?: \_\_\_\_\_

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How often do you check your blood sugar?:

Daily    Several times a week    Several times a month

I don't check my blood sugar

What does it usually read?: \_\_\_\_\_

What was your last A1C?: \_\_\_\_\_ What was the highest your A1C ever was? \_\_\_\_\_

Have you ever had a wound that is slow to heal (8-12 weeks)?:  Yes  No

If yes, where the location of the wound(s): \_\_\_\_\_

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Do you ever get any of the following? burning tingling numbness shooting pain

If so, how often do you get these sensations?: Daily Several times a week Several times a month Several times a year

Have you ever been diagnosed with Neuropathy? Yes No

If Yes, do you take medications for it? No

Gabapentin/Neurontin    Lyrica/Pregabalin    Metanx    Duloxetine/Cymbalta

Other Meds (including topical creams) \_\_\_\_\_