DIABETES CHRONIC DISEASE MANAGEMENT FORM

MINISTRY WELLNESS CENTER

PERSONAL INFORMATION

Full Name :

Date of Birth : D D M M Y Y

Gender : Male Female

E-Mail :

Phone Number :

Weight (lbs) :

Height :

MEDICAL HISTORY

Do you have a diagnosis of diabetes, prediabetes, insulin resistance, PCOS, metabolic syndrome, gestational diabetes, or glucose intolerance?

Yes

No

If yes, how long?
What is your last Hemoglobin A1C level?

Do you have an immediate family member with a history of diabetes (DM)? Yes No

SYMPTOMS

Are you experiencing frequent urination or dry mouth? Yes No

Are you experiencing abnormal weight loss or gain?

Yes, losing weight

Yes, gaining weight

No

BODY COMPOSITION

Is your Body Mass Index (BMI) 25% or greater? Yes No

BLOOD SUGAR LEVELS

Do you monitor your blood sugar at home?

Yes

No

If yes, have you ever recorded a fasting blood sugar level exceeding 126 mg/dL or a random blood sugar level surpassing 180 mg/dL?

THANK YOU FOR YOUR INFORMATION