Diabetes Review of Systems

Are you experiencing any of the following?

**HYPOglycemia**
- None
- Sweats
- Nausea
- Confusion
- Weakness

**HYPERglycemia**
- None
- Frequent urination
- Unusual thirst
- Blurred vision

**Any symptoms to suggest complications**
- None
- Vision problems
- Sexual dysfunction
- Nausea/vomiting/bloating
- Lightheadedness/near fainting
- Numbness or tingling
- Ulcerations or sores
- Chest pain or shortness of breath
- Pain in your legs when walking

Have you made any changes to your medicine since your last visit? Yes / No

How well do you think you are doing in eating the right foods for your diabetes? (circle one)
- Very Well
- Well
- OK
- Need Help

How much physical activity are you getting?

Do you feel you have the ability to take care of your diabetes? (circle one)
- Yes
- Somewhat
- Need Help

If not, how can we help?

_________________________________________________________

Patient Name: ____________________________ Date: ________________

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