Diabetes Review of Systems

Patient Name: _____ **Date:** _____

Are you experiencing any of the following?

HYPOglycemia

None	Yes / No
Sweats	Yes / No
Nausea	Yes / No
Confusion	Yes / No
Weakness	Yes / No

HYPERglycemia

None	Yes / No
Frequent urination	Yes / No
Unusual thirst	Yes / No
Blurred vision	Yes / No

Any symptoms to suggest complications

None	Yes / No
Vision problems	Yes / No
Sexual dysfunction	Yes / No
Nausea/vomiting/bloating	Yes / No
Lightheadedness/near fainting	Yes / No
Numbness or tingling	Yes / No
Ulcerations or sores	Yes / No
Chest pain or shortness of breath	Yes / No
Pain in your legs when walking	Yes / No

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?_____

_____

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