

Diabetes mellitus questionnaire – Attending physician

Full name:

1. When was diabetes first diagnosed?

2. Please confirm the type of diabetes

- a. Type 1 diabetes mellitus ☐
- b. Type 2 diabetes mellitus ☐
- c. Other(Please specify) ☐

3. Regarding your patient's treatment:

- a. Is oral medication prescribed? Yes ☐ No ☐
If Yes, please name the medication.
- b. Is insulin prescribed? Yes ☐ No ☐
If Yes, please state the type and dosage, including number of times used daily.

4. Regarding the management of diabetes mellitus:

- a. How well does the patient control their diabetes mellitus?
- b. Please provide any plasma glucose results, noting whether fasting or non-fasting, in the past 12 months.
- c. Please provide any urinalysis results in the past 12 months.
- d. Please provide any HbA1c results in the past 12 months.
- e. How often does the patient attend your practice or clinic for monitoring?
- f. When was your last consultation?
- g. Please provide the name and address of any other clinic or doctor supervising treatment.

5. Since treatment began, has the patient ever experienced episodes of hypoglycaemia requiring hospitalization, or admission to hospital due to diabetic coma, ketoacidosis or any condition related to a diabetes related condition? If yes, please provide full details, including dates.

Yes ☐ No ☐

6. Has the patient ever had any of the following?

- a. Proteinuria or albuminuria Yes ☐ No ☐
- b. Nephropathy Yes ☐ No ☐
- c. Retinopathy Yes ☐ No ☐
- d. Neuropathy Yes ☐ No ☐
- e. Hypertension Yes ☐ No ☐
- f. Ischaemic heart disease Yes ☐ No ☐

- g. Peripheral vascular disease
If Yes, please provide full details.

Yes ☐ No ☐

7. Has the patient ever undergone any of the following investigations?

- a. Resting and or effort electrocardiogram
b. Blood tests for lipids or renal functions?
If Yes, please provide full details.

Yes ☐ No ☐
Yes ☐ No ☐

8. Has the patient been off work for 15 or more days due to any illness in the past year? If Yes, please provide full details.

Yes ☐ No ☐

9. Which other disorders or risk factors (eg. smoking) are present that may influence the prognosis?

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.

Signature

Printed name or clinic stamp

Date