DAISY-OTHER DIABETES DIAGNOSIS

ID# _____

Have you been diagnosed with diabetes? No ☐

Yes ☐ Date: _____

What type of diabetes were you diagnosed with?

Type 2 ☐ Gestational ☐ Other ☐

Where diagnosed: Dr office ☐ Provider?_____

ER ☐ Where?_____

Hospitalized? No ☐ Yes ☐ Where?_____

Can DAISY obtain your medical records related to this diagnosis? No ☐ Yes ☐ (get med release)

Blood sugar at time of diagnosis: _____

A1c at time of diagnosis: _____

What symptoms did you have prior to diagnosis? (mark all that apply)

Increased thirst ☐ Nausea ☐

Increased urination ☐ Vomiting ☐

Weight loss ☐ Vision changes ☐

Decreased energy ☐

Have you ever taken insulin shots? No ☐ Yes ☐

If yes, are you still using insulin? No ☐ Yes ☐

How did/do you treat your diabetes? (mark all that apply)

Diet and exercise ☐

Pills ☐ Please list diabetes medications _____

_____

Have your parents or siblings been diagnosed with diabetes?

Name:_____DAISY ID# _____, Type: _____, Date/Age_____ ,
Has this person ever taken insulin shots? No ☐ Yes ☐

Name:_____DAISY ID#_____, Type: _____, Date/Age_____ ,
Has this person ever taken insulin shots? No ☐ Yes ☐

Name:_____DAISY ID#_____, Type: _____, Date/Age_____ ,
Has this person ever taken insulin shots? No ☐ Yes ☐