Name:_____ Date_____

1. How many years have you been diabetic? _____
2. At what age did your diabetes begin? _____
3. Are you diet controlled? Yes____No____
4. Do you take medicine for your diabetes? Yes____No____
   If yes, what kind?
   Insulin___ Diabinese___ Tolirfase___ Orinase___ Other___
5. Do you see an MD for your diabetes? Yes____No____
   If yes, how often? _____
6. Do you have regular urine test for your diabetes? Yes____No____
7. Do you have regular blood tests for your diabetes? Yes____No____
8. If the answer to 6 or 7 was yes, how often? _____
9. Do you perform home tests for your diabetes? Yes____No____
10. Do you have any problems with your blood circulation? Yes____No____
    If yes, are you under the care of a doctor? _____
11. Do you have any problems with your nerve sensation? Yes____No____
    If yes, are you under the care of a doctor? _____
12. Do you have any problems with your skin? Yes____No____
    If yes, are you under the care of a doctor? _____
13. Do you smoke? Yes____No____
    If yes, how often? _____
14. Do you feel handicapped by your diabetes? Yes____No____
15. Have you ever sought counseling for your diabetes? Yes____No____
16. Do any other family members have diabetes? Yes____No____
    If yes, who in your family? _____
17. Do you have any foot problems? Yes____No____
    If yes, what kind? _____
18. Do you currently see a foot doctor? Yes____No____
    If yes, how often? _____
19. Have you ever had any foot surgeries? Yes____No____
    If yes, what kind? _____
    If yes, were there any complications? Yes____No____

Comments: