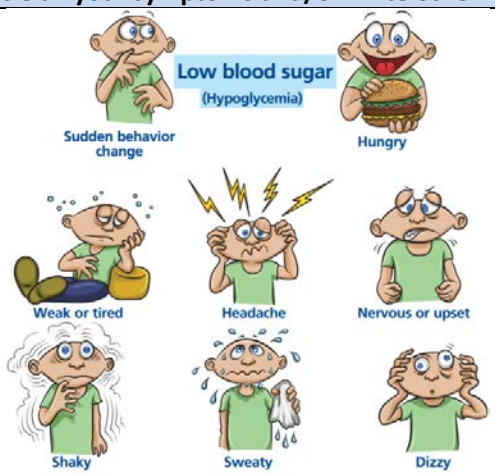
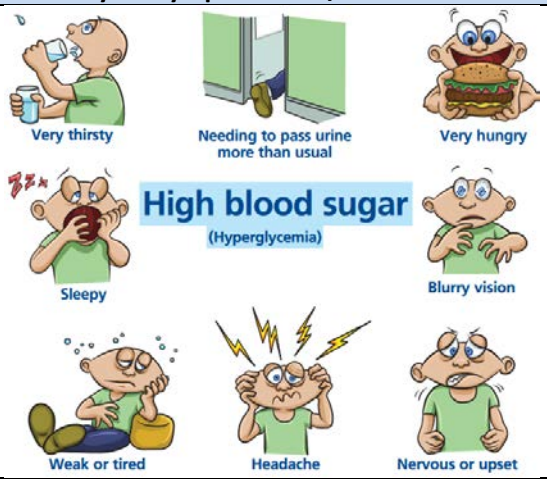
Pediatric Specialists of Virginia

Children's National INOVA

Department of Pediatric Endocrinology
Diabetes Follow Up Questionnaire

Clinician Name: _____

Today's date _____ / _____ / _____	
PATIENT NAME:	**DOB** _____ / _____ / _____
Accompanying adult:	**Relationship to patient:**
Any concerns or questions you would like to discuss today?	
What Grade and school do you attend? How do you like to spend your free time? (Sports, Music, Reading, Art, Video Games…..)	
How many times a month do you miss school due to a diabetes related event?	
How do you feel with a LOW blood sugar? Please circle all your symptoms and/or write other	**How do you feel with a HIGH blood sugar? Please circle all your symptoms and/or write other**
	
What do you use to treat?	What do you do when your blood sugars are high?
Do you have anything to treat with you now? ☐ **No** ☐ **Yes**	
When do you wear a medical alert ID? ☐ **Never** ☐ **Sometimes** ☐ **Only in car** ☐ **Only with Sports** ☐ **Always**	

What **Fast Acting Insulin** do you use? ☐ **Novolog** ☐ **Humalog** ☐ **Apidra**				
Tell Us About Your Daily Schedule:				
Meal	**Time**	**Insulin-to-carb ratio**	**Correction factor (ex - 1unit / 50pt > 150)**	**How many total units is this on a typical day?**
Breakfast				
Lunch				
Dinner				
Any Snacks?				
What **Long Acting Insulin** do you use? ☐ **Lantus** ☐ **Levemir** ☐ **NPH**				
What is your dose?			What time do you take it?	

Please complete both sides of this questionnaire, which helps us serve you better. Thank you.

Patient Identification
If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Office Use Only
I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
___It was emergency treatment
___I could not communicate with the patient
___The patient refused to sign
___The patient was unable to sign because
___Other (please describe)

Signature _____

INJECTIONS	
What do you use?	☐Syringe ☐ Insulin pen
If an insulin pen, what length pen needle?	☐ Nano: green ☐ Mini: purple ☐ Short: blue
What sites do you use?	☐Arms ☐ Legs ☐ Abdomen ☐ Buttocks
Does insulin ever leak from the injection site?	☐ **No** ☐ **Yes**
Any pain with injections?	☐ **No** ☐ **Yes**
Who does insulin injections?	☐Self ☐ Parents ☐ Nurse ☐ Sibling ☐ Other

INSULIN PUMP	
What Brand Pump are you on?	☐Animas ☐ Medtronic ☐ OmniPod ☐ T Slim ☐ Other _____
How long have you had your current insulin pump?	
Do you know how to upload at home?	☐ **No** ☐ **Yes**
Do you know how to use advanced features?	☐ **No** ☐ **Yes**
Insulin pump insertion sites	
What infusion set do you use? (please name)	
What sites do you use?	☐ Arms ☐ Legs ☐ Abdomen ☐ Buttocks
How often do you change sites?	☐ Every 2 days ☐ Every 3 days ☐ Other ____
Any pain with insertions?	☐ **No** ☐ **Yes**
Who does insertions?	☐Self ☐ Parents ☐ Nurse ☐ Sibling ☐ Other

CONTINUOUS GLUCOSE MONITOR	
If you are not using a CGM, are you interested in learning more about them?	☐ **No** ☐ **Yes**
If you use a CGM, which one do you use? (please circle)	☐ DexCom ☐ Animas Vibe ☐ T Slim G4 ☐ Medtronic ☐ Enlite
Do you know how to upload at home?	☐ **No** ☐ **Yes**
Do you know how to "share" data?	☐ **No** ☐ **Yes**

Since your last visit, have you:		**If yes, please provide details**
Experienced any new illnesses, surgery or hospitalizations?	☐ **No** ☐ **Yes**	
Had blood work, x rays, ultrasound, CAT scan or MRI?	☐ **No** ☐ **Yes**	
Changed any medications including non-prescription?	☐ **No** ☐ **Yes**	
Learned of relatives that have developed a new chronic illness?	☐ **No** ☐ **Yes**	
Experienced any major change at home, school, work, or in personal situation or health (e.g. diet, exercise, tobacco use, alcohol use)?	☐ **No** ☐ **Yes**	
Since your last visit have you experienced any change in symptoms:		**If yes, please provide details**
Fever, fatigue, feeling too warm or too cold most of the time	☐ **No** ☐ **Yes**	
Weight loss, weight gain, increased thirst	☐ **No** ☐ **Yes**	
Eyes / Vision (blurred or double vision, tearing, swelling)	☐ **No** ☐ **Yes**	
Ears, nose, mouth, throat (Swelling, tender, difficulty swallowing, unable to smell, snoring, frequent ear infections, hearing problems)	☐ **No** ☐ **Yes**	
Heart (chest pain, palpitations)	☐ **No** ☐ **Yes**	
Lungs (shortness of breath, cough)	☐ **No** ☐ **Yes**	
Digestion (constipation, diarrhea, belly pain, vomiting)	☐ **No** ☐ **Yes**	
Urinary (pain with urination, frequent urination, bedwetting)	☐ **No** ☐ **Yes**	
Muscles, joints (aches, cramps, pain on walking)	☐ **No** ☐ **Yes**	
Skin, nails and hair (dryness, brittle nails, hair loss)	☐ **No** ☐ **Yes**	
Neurological (Headaches, numbness, weakness, dizziness)	☐ **No** ☐ **Yes**	
Emotional (Depression, sleep disorder, difficulty concentrating, anxiety)	☐ **No** ☐ **Yes**	
Reproductive (change in menstruation, body odor, early pubic/axillary hair, age of first period ever and date of last period- if applicable)	☐ **No** ☐ **Yes**	