



Diabetes Education and Wellness  
 1910 Route 35, Oakhurst, NJ 07755  
 Tel: 732-676-8381 Fax: 732-876-3059

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Did you have any **illness or surgery** since last visit? NO \_\_\_ **Yes: What/When** \_\_\_\_\_

Any **changes in medication**? NO: \_\_\_\_\_ **Yes: When/Who?** \_\_\_\_\_

Please **list changes in medication** \_\_\_\_\_

Did you have any **new bloodwork or test**? NO \_\_\_ **Yes: when/where** \_\_\_\_\_

**Nutrition:** Are you on meal replacement? No --**If YES Optifast/Healthwise or OTC:** \_\_\_\_\_

Yes: # Formula: \_\_\_\_\_ #Bar: \_\_\_\_\_ # Soup \_\_\_\_\_ **per day**

**Hydration:** Water \_\_\_\_\_ oz Coffee/tea: \_\_\_\_\_ oz Soda Diet/Regular: \_\_\_\_\_ oz

**Activity:** How many **days per week?** \_\_\_\_\_ **How long per session?** \_\_\_\_\_ minutes/miles

**With exercise:** Any chest pain, palpitation, low blood sugar, change in activity tolerance? \_\_\_\_\_

**Signs and symptoms SINCE PROGRAM/MEDICATION started**

Chest pain	Depression	Confusion	Fatigue	Indigestion	Palpitation
Cramps/gas	Diarrhea	Constipation	Headaches	Lack of control	Rashes
Cravings	Dizziness	Fainting	Hunger	Nausea	Swelling
Cold extremities	Difficulty of sleeping	Irritability/Anger	Lack of interest	Numbness	Shortness of breath
<b>Other:</b>					

**BLOOD SUGAR**

	Pre breakfast	PreLunch	Pre Dinner	Bedtime	Other
LOWEST					
HIGHEST					

**BP**

Date	AM BP /HR	PM BP/HR

**Follow up:**

	Reason:	Visit	
		Last	Next
PCP			
Endocrine			
Ophthalmology			
Psychology			
Exercise/Gym			
Podiatry			
Cardiology			

**Vaccine:**

Flu	Pneumonia	Shingles	Tetanus/whooping cough	other

BP: \_\_\_\_\_ Temp't : \_\_\_\_\_ Pulse: \_\_\_\_\_ O2 Sat: \_\_\_\_\_ Pain **/10** Where \_\_\_\_\_

Questions/other concerns: