Outcomes

DIABETES TESTING/INJECTION SUPPLIES

PATIENT INFORMATION *(Please print clearly)*

Last Name: **First Name:**	**D.O.B.:** **Age:** **Gender:** **Height:** **Weight:**
Home Address:	Contact Phone:
City:	State: Zip:
Primary Care Physician:	Physician Phone:
Physician Address:	Physician Fax #:
Please state any past medical history and chronic conditions:	
Current medications:	
Allergies (please state reaction that occurs when exposed to the allergen):	

SCREENING QUESTIONNAIRE

	Yes	**No**	**Don't Know**
Have you been diagnosed with Diabetes by a healthcare provider?	☐	☐	☐
Do you currently smoke tobacco? *If yes, how many packs per day?*	☐	☐	☐
Do you currently consume alcohol? *If yes, how many drinks per week?*	☐	☐	☐
Do you currently use any recreational drugs? *If yes, please indicate which drugs and how often:*	☐	☐	☐
Do your symptoms of allergic rhinitis impair sleep or daily activities?	☐	☐	☐
Are you currently experiencing any of the following symptoms: increased frequency of urination, excess thirst, weight loss, dehydration, vomiting, weakness, mental status changes?	☐	☐	☐