Drs Michael Kotkin, Lawrence Ostroff and Alan Morris, D.P.M.,PC
70 Glen Street, Suite 300
Tel: 516-676-1116/0557 Fax: 516-676-2710

DIABETIC QUESTIONNAIRE
To Be Completed by Diabetics Only

Patient: _____ Date: ___/___/___

Type of Diabetes: Type I ☐ Type II ☐

When were you 1st diagnosed? Date: ___/___/___

Is your diabetes under control? If so, is it controlled by:
Diet ☐ Insulin ☐ Medication ☐ Other _____

Do you regularly check your glucose levels? Yes ☐ No ☐

Last time you checked your glucose? Date: ___/___/___

What was your last blood sugar _____ A1c_____

Name of primary doctor treating diabetes: _____

Date of last visit with Primary Care Dr. _____

Any known complications resulting from diabetes:
Eyes ☐ Circulation ☐ Nerves ☐ Heart & Blood Vessels ☐ Kidneys ☐
Gums & Teeth ☐ Other _____