



Screening Form

Date:

Name:

DOB:

Dx of DM? Yes No

Current Medications:

Drug/Dose	Directions	Drug/Dose	Directions

Subjective:

Risk Factors

- Family History (parent/sibling)
- Age > 45
- BP > 140/90 or on BP meds
- High LDL, high TGs (>250), or low HDL (<40)
- Overweight (see chart)
- Physical inactivity
- Hx of gestational diabetes or birth to child >9lbs
- Polycystic ovary syndrome

Signs and Symptoms

- Yes No Frequent urination
- Yes No Excessive thirst
- Yes No Excessive hunger
- Yes No Fatigue
- Yes No Dry skin
- Yes No Vision changes
- Yes No Neuropathy
- Yes No UTIs
- Yes No Vaginitis/Yeast infection
- Yes No Weight gain or loss

Time of last consumed food or beverage?

At least 8 hours ago? Yes No

Food Consumed?

Is the patient pregnant? Yes No

Objective:

Blood Glucose reading: _____ mg/dl

Meter #:

Strip Lot #:

Strip Exp. Date:

Assessment:

- Blood glucose normal (not at risk for DM)
- Blood glucose normal (at risk for DM)
- Blood glucose elevated
- Well controlled Diabetes
- Uncontrolled Diabetes

Diabetes Risk Test Score:
(from other sheet)

Plan:

- No referral
- Return for fasting blood glucose level
- Refer to MD for further evaluation
- Other _____

Please place additional notes
on backside.

Signature/Date: