Vermont CDL Exams

Patient_________________________________ DOB____________ Date___________

Diabetes Questionnaire

Do you have diabetes mellitus or elevated blood glucose? Yes   No

If yes, how is it controlled? (please be specific)

1. Diet ____
2. Pills ____
3. Insulin ____
4. Other injectable medications ____

Do you:

1. Routinely monitor blood glucose level? Yes   No   Where is it typically? _________________
2. Use over-the-counter medications and/or supplements? _______________________________
3. Use an incretin mimetic (Bydureon, Byetta, Victoza, exenatide or liraglutide)?______________
4. Have a history of fainting, dizziness, or loss of consciousness?
5. Have a history of hypoglycemic reactions (low blood sugar) that resulted in:
   a. Seizure ____
   b. Loss of consciousness ____
   c. Need of assistance from another person _________________________________
   d. Period of impaired cognitive function that occurred without warning_________________

If so, have you had one or more occurrences within last 12 months? Yes   No

Two or more occurrences within last 5 years? Yes   No

Please give any other information you feel is important in regard to your diabetes: __________________

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Signature:___________________________________   Date: ___________________

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