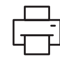
TANDEM
Diabetes Care

HEALTH AND PRODUCT QUESTIONNAIRE

This form can also be filled out online at tandemdiabetes.com



Fax completed form to
(619) 810-2304

PATIENT'S NAME (FIRST, MIDDLE, LAST)			DATE OF BIRTH (MM/DD/YYYY) / /
HEIGHT _______feet _______inches	WEIGHT _____________lbs.	DATE OF DIAGNOSIS (MM/YYYY) /	SEX ☐ Male ☐ Female ☐ Decline to State

TELL US ABOUT YOUR DIABETES

DIABETES TYPE ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: ______________		NUMBER OF BLOOD GLUCOSE TESTS PER DAY	CURRENT INSULIN ☐ NovoLog ☐ Humalog ☐ Apidra ☐ Lantus ☐ Other: _______________
HIGHEST AND LOWEST BLOOD GLUCOSE VALUE (WITHIN THE LAST THREE MONTHS) _________(High) _________(Low)		LATEST HbA1c – RESULT _______ . _____% DATE (MM/DD/YYYY) / /	
ARE YOU CURRENTLY PREGNANT? ☐ Yes ☐ No	ARE YOU PLANNING A PREGNANCY? ☐ Yes ☐ No	PRIOR HbA1c – RESULT _______ . _____% DATE (MM/DD/YYYY) / /	

CURRENT DIABETES THERAPY: ☐ Insulin Pump ☐ Multiple Daily Injections ☐ Other: ________________________________

⬇ IF PUMP USER ⬇			⬇ IF MULTIPLE DAILY INJECTION USER ⬇	
MANUFACTURER	MODEL	INFUSION SET	NUMBER OF INJECTIONS PER DAY	NUMBER OF UNITS PER DAY
DATE OF PURCHASE (MM/DD/YYYY) / /	DID CURRENT INSURANCE PAY FOR THIS PUMP? ☐ Yes ☐ No		HAVE YOU EVER BEEN ON A PUMP? ☐ Yes (please also answer questions below) ☐ No	
PAST PUMP HISTORY (IF ANY): PUMP MODEL, PURCHASE DATE, MALFUNCTIONS (E.G., ISSUES, ERRORS, WEAR/TEAR)				CURRENT CGM USER? ☐ Yes (model) ___________ ☐ No

PLEASE CHECK YES OR NO TO THE FOLLOWING

⬇ HAS YOUR PRESCRIBING HEALTHCARE PROVIDER DIAGNOSED YOU FOR ANY OF THE FOLLOWING ⬇

1. Diabetic ketoacidosis (dangerous condition with dehydration, insulin deficit, and high level of ketones present in the blood/urine)........ ☐ Yes ☐ No
2. Hyperglycemia (a higher-than-normal level of glucose in the blood)........ ☐ Yes ☐ No
3. Hypoglycemic unawareness (inability to sense when your blood sugar is low)........ ☐ Yes ☐ No
4. Nocturnal hypoglycemia (low blood glucose readings while sleeping)........ ☐ Yes ☐ No
5. Recurrent hypoglycemia (frequent daytime lows)........ ☐ Yes ☐ No
   - ▸ Any assistance with low blood glucose within the last two years?........ ☐ Yes ☐ No
   - ▸ If yes, please describe: ________________________________
6. Dawn phenomenon (wake up with an increase in glucose readings)........ ☐ Yes ☐ No
7. Retinopathy (eye disease)........ ☐ Yes ☐ No
8. Gastroparesis (slowed stomach emptying)........ ☐ Yes ☐ No
9. Nephropathy (kidney problem)........ ☐ Yes ☐ No
10. Post-renal transplant?........ ☐ Yes ☐ No
11. Neuropathy (pain, numbness, tingling or burning in hands or feet, increased heart rate, low blood pressure, delayed digestion, erectile dysfunction) ... ☐ Yes ☐ No
12. Cardiovascular disease (heart attack or stroke)........ ☐ Yes ☐ No

⬇ IN THE PAST TWO YEARS, DID YOU HAVE DIABETES-RELATED... ⬇

13. Hospitalization?........ ☐ Yes ☐ No
    - ▸ If yes, please describe: ________________________________
14. Pump training/education?........ ☐ Yes ☐ No
    - ▸ If yes, please describe: ________________________________
15. Weight loss?........ ☐ Yes ☐ No
    - ▸ If yes, please describe: ________________________________

INFORMATION COMPLETED BY

PRINT FULL NAME	SIGNATURE	DATE (MM/DD/YYYY)
	X	/ /

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