



Diabetic Check-in Questionnaire

Client Name: _____

Patient: _____

Date: _____

How much insulin do you give? _____ Units

What type of insulin? _____

How long has the bottle been open? _____

When do you give the insulin? am _____ pm _____

When and what do you feed?

Brand: _____

Amount: am _____ pm _____

Time fed: am _____ pm _____

What in-between-meal snacks do you give and when?

Brand: _____

Time fed: am _____ pm _____

Other: _____

What type of exercise and when do you exercise your pet?

If you check urine sugars, what have the last several readings been?

Any change in urination habits or drinking habits?

Any weight loss or gain?

Any concerns?

Owner should leave with us:

- Bottle of insulin
- Syringes
- Food
- Snacks

Signature _____

Phone number where you can be reached for additional questions: _____