Iowa Diabetes & Endocrinology Center
Health Tracker

Name: ________________________________ Date: ________________________________

HISTORY

Changes in YOUR health since last OV? ____________________________________________

Significant changes in family medical history? _______________________________________

Do you see any specialists regularly? ______________________________________________

Do you smoke/use tobacco products? Yes No Do you take daily aspirin? Yes No

Are you considering PREGNANCY? Yes No Do you need refills today? Yes No

(females only)

BLOOD SUGARS

How often are you testing your blood sugars? __________________

PLEASE COMPLETE 14 DAY BLOOD SUGAR LOG ON BACK OF THIS SHEET

***OR***

Describe the RANGES of your blood sugar below (example: 100 to 150 before lunch)

Before Breakfast

Before Lunch

Before Dinner

Bedtime

After Meals

Other

How often do you have LOW blood sugars? _______/per week When? _________________

DIET AND ACTIVITY

Rate your diet: Good Fair Poor Describe diet: ______________________________________

How often do you exercise? __________________ What type? _________________________

REVIEW OF SYSTEMS

Please mark any symptoms you have experienced within last month:

____ Chest Pain

____ Fast/irregular heart beat

____ Fainting

____ Shortness of breath

____ Swelling in legs/ankles

____ Cough

____ Wheezing

____ Snoring

____ Numbness/tingling in feet

Date of last eye exam? _________________ Date of last foot exam? _________________
<table>
<thead>
<tr>
<th>Date</th>
<th>Before Breakfast</th>
<th>After Breakfast</th>
<th>Before Lunch</th>
<th>After Lunch</th>
<th>Before Dinner</th>
<th>After Dinner</th>
<th>Bedtime</th>
<th>Night</th>
<th>Comments</th>
</tr>
</thead>
</table>

**Insulin Pump Worksheet**

*(Complete only if you wear an insulin pump)*

**My Current Basal Rates:**

<table>
<thead>
<tr>
<th>Basal Rate</th>
<th>Time</th>
<th>Units/Hr</th>
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<tbody>
<tr>
<td>Rate 1</td>
<td>12:00am</td>
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<td>Rate 9</td>
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</tbody>
</table>

**Avg Total Daily Dose of Insulin:** _____

**My Insulin to Carb Ratios (ICR):**

- **Breakfast:** 1 unit for: ____ grams carb
- **Lunch:** 1 unit for: ____ grams carb
- **Dinner:** 1 unit for: ____ grams carb

**Insulin Sensitivity Factor (ISF):**

1 unit of insulin will lower my blood glucose

- ____ mg/dL in daytime
- ____ mg/dL in nighttime

**Blood Glucose Target Ranges:**

_____ to _____ mg/dL

**Active Insulin On Board:** _____ hours