

# AIRMEN DIABETES STATUS REPORT

Airman's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1) Diagnosis: \_\_\_\_\_

2) All Medications and dosages: \_\_\_\_\_

\_\_\_\_\_

3) Adverse medication side effects experienced by patient: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4) Maintaining diabetic diet Yes \_\_\_\_\_ No \_\_\_\_\_

5) Hemoglobin A1C result done within the last 30 days:

Reading: \_\_\_\_\_ Date of test: \_\_\_\_\_

6) Any history of hypoglycemic events? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain with

date and circumstances \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7) Complications: Cardiac \_\_\_\_\_ Peripheral vascular \_\_\_\_\_

Renal \_\_\_\_\_ Other \_\_\_\_\_ None \_\_\_\_\_

8) Any changes or new treatments? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Name: \_\_\_\_\_

(Please print)

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_