



Prediabetes Screening Form

Could You Have Prediabetes?

Prediabetes means your blood glucose (sugar) is higher than normal, but not yet diabetes. Diabetes is a serious disease that can cause heart attack, stroke, blindness, kidney failure, or loss of feet or legs. Type 2 diabetes can be delayed or prevented in people with prediabetes through effective lifestyle programs. Take the first step. Find out your risk for prediabetes.

Name _____ Birth Date _____ / _____ / _____ Age _____

Address _____ City/State/Zip Code _____

Phone _____ Email _____

Gender: (circle) Male Female

Attending Physician _____

- YES NO 1. Are you a woman who has had a baby weighing more than 9 pounds at birth?
- YES NO 2. Do you have a sister or brother with diabetes?
- YES NO 3. Do you have a parent with diabetes?
- YES NO 4. Find your height on the chart. Do you weigh as much as or more than the weight listed for your height?
- YES NO 5. Are you younger than 65 years of age and get little or no exercise in a typical day?
- YES NO 6. Are you between 45 and 64 years of age?
- YES NO 7. Are you 65 years of age or older?

AT-RISK WEIGHT CHART			
Height	Weight (lbs.)	Height	Weight (lbs.)
4'10"	129	5'8"	177
4'11"	133	5'9"	182
5'0"	138	5'10"	188
5'1"	143	5'11"	193
5'2"	147	6'0"	199
5'3"	152	6'1"	204
5'4"	157	6'2"	210
5'5"	162	6'3"	216
5'6"	167	6'4"	221
5'7"	172		

In consideration of my participation in this program, I agree to the following: The information provided on this form, to the best of my knowledge, is complete and correct. Participation is voluntary and may include taking a personal and family medical history, blood pressure measurements, use of Doppler ultrasound instruments, listening to blood flow, referring me to my doctor or other medical provider for follow up consultation. A low risk assessment is not a guarantee of good health and this screening does not substitute for a consult/physical exam by a physician. I hereby release and agree to hold harmless Riverside Medical Center and/ or its affiliates and any employee thereof, as well as the site conducting this screening, including but not limited to injury or illness arising in any way from participating in this program. All medical information obtained through my participation in this program will be kept confidential.

Signature: _____

Date: _____