HYPOGLYCEMIA

Patient Name: _____ **Date:** _____

For each of the following symptoms, circle one number only:
0 if the symptoms is not present
1 if the symptoms is present but very mild
2 if the symptoms is present but moderate
3 if the symptoms is present and extremely severe

1.	Crave sweets	0 1 2 3
2.	Irritable if a meal is missed	0 1 2 3
3.	Feel tired or weak if a meal is missed	0 1 2 3
4.	Dizziness when standing suddenly	0 1 2 3
5.	Frequent headaches	0 1 2 3
6.	Poor memory (forgetful) or concentration	0 1 2 3
7.	Feel tired an hour or so after eating	0 1 2 3
8.	Heat Palpitations	0 1 2 3
9.	Feel shaky at times	0 1 2 3
10.	Afternoon fatigue	0 1 2 3
11.	Visions blurs on occasion	0 1 2 3
12.	Depression or mood swings	0 1 2 3
13.	Overweight	0 1 2 3
14.	Frequently anxious or nervous	0 1 2 3
	TOTAL:	