

Glucose Tolerance Test

Patient Information:

Full Name:

Age:

Gender:

Date of Birth:

Address:

Contact Number:

Email Address:

Medical History:

Have you been previously diagnosed with diabetes? (Yes / No):

Are you currently on any medication? (Yes / No):

If yes, please list:

Have you had any surgeries in the past? (Yes / No):

If yes, please specify:

Do you have any known allergies? (Yes/No):

If yes, please specify:

Family history of diabetes: (Yes / No):

Findings/Diagnosis

Fasting Blood Glucose Level: _____ mg/dL

1-hour Blood Glucose Level: _____ mg/dL

2-hour Blood Glucose Level: _____ mg/dL

3-hour Blood Glucose Level: _____ mg/dL

Diagnosis

- Normal
- Impaired Glucose Tolerance
- Diabetes

Recommendations

- Lifestyle modifications (diet, exercise, etc.)
- Medication
- Referral to a specialist
- Other:

Follow Up

Next Appointment Date:

Notes for Patient:

Additional Tests Recommended:

Doctor's Signature:

Date: