BLOOD SUGAR INSTABILITY QUESTIONNAIRE

Name: _____

Do any of the following apply to you?

Yes	No	
☐	☐	Family history of diabetes, hypoglycemia or alcoholism
☐	☐	Calmer after meals
☐	☐	Frequent thirst
☐	☐	Night sweats (not menopausal)
☐	☐	Crave salt foods
☐	☐	Dark circles under eyes or eyes sensitive to bright light
☐	☐	More awake at night
☐	☐	Food cravings
☐	☐	Headaches
☐	☐	Irritability
☐	☐	Mood swings
☐	☐	Easily fatigued
☐	☐	Anxiety
☐	☐	Difficulty sleeping
☐	☐	Mental sluggishness

- ☐ ☐ Eat when nervous
- ☐ ☐ Excessive appetite for carbohydrates or sweets
- ☐ ☐ Hungry between meals
- ☐ ☐ Irritable before meals
- ☐ ☐ “Shaky” if hungry
- ☐ ☐ Lightheaded if skip meals
- ☐ ☐ Low energy in afternoon
- ☐ ☐ Afternoon headaches
- ☐ ☐ Crave sweets or coffee in afternoon