Diabetes Patient Assessment

Please fill out this questionnaire and bring it to your first appointment. ***All information is confidential.***

General Information:

Today's Date: _____

Name: (Last) _____ (First)_____

Date of Birth: _____ Age: _____

Primary Physician: _____

Which doctor referred you to this program? _____

How did you hear about this program? _____

Email Address: _____

Home phone: _____ Work phone:_____

May we call you at your work number if necessary? ❒Yes ❒No

Sex: ❒Male ❒Female

Check your racial/ethnic group:

❒ White/Caucasian ❒Asian/Pacific Islander
❒ Hispanic/Mexican/Latino ❒ Native American
❒ African American /Black ❒ Other_____

Marital Status: ❒Single ❒Divorced
❒Widowed ❒Married (Spouse's name_____)

Personal History:

Do you work? ❒No ❒Yes ❒Retired ❒Disabled ❒Student

Type of job and work hours?_____

Who lives with you?_____

How far did you go in school?_____

What language do you use at home?_____

Do you have worries about the cost of diabetes care? ❒No ❒Yes

If you have insurance, does it cover your diabetes supplies? ❒No ❒Yes ❒Not sure

Having diabetes makes me feel (check all that apply):

❒Angry ❒Frustrated
❒Scared ❒Accepting
❒Depressed ❒Resigned
❒Alone ❒Other_____

What things, if any, will make it hard for you to take care of your diabetes?

❒Transportation ❒Family ❒Illness ❒Reading
❒Money ❒Work ❒Vision / hearing ❒Other_____

Who supports you in your efforts to manage your diabetes?

❒spouse ❒mother/father ❒friends ❒Doctor Other_____
❒children ❒relatives ❒co-workers ❒Nurse ❒ No one

Diabetes History:

What **type of diabetes** do you have?

❒Type 2 ❒Pre-diabetes ❒Not sure
❒Type 1 ❒Gestational Diabetes

How long have you had diabetes or when were you diagnosed? _____

Have you had diabetes education before? ❒No ❒Yes When / Where?_____

Monitoring:

Do you check your blood sugar? ❒No ❒Yes

If yes, **what brand is your meter**?_____

How often do you check your blood sugar?

❒Less than once daily ❒4-5 times daily
❒Once daily ❒more than 5 times daily
❒ 2-3 times daily ❒Other_____

At what times of the day do you check your blood sugar?

_____

Have you ever had a **low blood sugar**? (less than 70) ❒No ❒Yes
How often?_____ When?_____

Have you ever had a **high blood sugar**? (over 250?) ❒No ❒Yes
How often?_____ When?_____

Review your glucose log over the past month

- If you are checking **fasting levels** (first thing when you wake up):
  - What was your lowest reading? _____ Your highest reading? _____
- If you are checking **2 hours after meals**:
  - Your lowest reading? _____ Your highest reading? _____
- If you are checking **before meals**:
  - Your lowest reading? _____ Your highest reading?_____

Do (or did) any of your **family members** have diabetes? ❒No ❒Yes Who?_____

Do you **smoke or use tobacco**? ❒No ❒Yes ❒ I quit (date)_____
If yes, for how long?_____How much?_____
If yes, would you like information about quitting? ❒No ❒Yes

Do you **drink alcohol**? ❒No ❒Yes
If yes, how often do you usually drink? ❒Daily ❒2-4 times / week
❒ Once a week ❒Occasionally ❒Other:_____

What type of drinks?
❒Beer ❒Wine ❒Mixed drinks ❒ Distilled liquor ❒Other_____

Have you seen a doctor in the past 12 months? ❒No ❒Yes
For what reason?_____Date?_____

Have you been to the Emergency Room in the last year? ❒No ❒Yes
For what reason?_____Date?_____

Vaccinations:

- Do you get **flu shots**? ❒No ❒Yes Date of last flu shot:_____
- Have you ever had a **pneumonia shot**? ❒No ❒Yes Date of last shot:_____

Dental: When was your last dental exam?_____

Eye Exam: When was your last eye exam?_____

Medical History: Have you ever or do you now have any of the following:

Condition	When Diagnosed?
❒High Cholesterol	
❒Heart Disease	
❒High blood pressure	
❒Stroke	
❒Poor leg circulation	
❒Eye Disease	
❒Skin Problems	
❒Recent/Frequent Infections	
❒Kidney Problems	
❒Lung Disease / Asthma	
❒Dental Disease	
❒Depression	
❒Foot Problems	
❒Sexual Problems	
❒Chronic Pain / Chronic Fatigue	
❒Thyroid Disease	
❒Mental health problems	
❒Osteoporosis	
❒Amputation	
❒Cancer	
❒Seizure Disorder	
❒Sexually Transmitted Disease	
❒Other problems:	

Surgeries: List any surgeries (and date) you have had:_____

_____

_____

ALLERGIES

Are you allergic to any medications? ❒Yes ❒No

Which medication(s)_____

Any food allergies?_____ Seasonal allergies?_____

Medication:

Please list all your medications. Include those needing a prescription and those not needing a prescription "over-the-counter" (pain relievers, aspirin, etc.) (attach sheet if necessary)

Name of Medication	Dose and When Taken	What is it for?

Insulin: Do you use Insulin? ❒No ❒Yes

If yes, do you use: ❒a syringe ❒an insulin pen ❒insulin pump

Supplements: Please list any vitamins, herbs, supplements or home remedies you use

Vitamin / supplement / herbs / home remedy / tea	What do you take it for? How often?

Exercise/Activity:

Do you exercise? ❒No ❒Yes: What type of exercise do you do?_____

How often:_____ How long each session?_____

Does your work involve exercise or physical activity? ❒No ❒Yes

What level of activity is required? ❒ high activity ❒ medium ❒ low ❒ sedentary

Foot Care History:

Have you ever seen a podiatrist? ❒Yes ❒No

If yes, when and for what?_____

When was your last visit? _____

What kind of shoes do you wear?_____ Do you go barefoot? ❒Yes ❒No

Do you shave the top of your feet or toes? ❒Yes ❒No

Have you ever had or do you have any of the following: (please check all that apply)

❒Foot pain
❒Numbness in feet
❒Burning in feet
❒Tingling in feet
❒Leg or foot cramps at night
❒Vascular surgery
❒Fungal infection
❒Cold feet
❒Leg cramps while walking
❒Foot or leg ulcers
❒Problem toenails (describe)_____
❒Foot surgery (describe)_____
❒Slow healing cuts or blisters

How do you care for your feet now? (Please check all that apply)

❒ Inspect my feet daily
❒Cut my own toenails
❒Use an ingrown toenail medicine
❒File my nails
❒Cut my own calluses or corns
❒Use a foot powder
❒Use wart remover
❒Use callus sander or pumice stone
❒Use corn pads (Medicated? ❒Y ❒ N)
❒Use Moleskin
❒Soak my feet in a basin regularly
❒with Epsom salts? ❒With other additives?
❒Use lotion

For Women only:

Number of pregnancies:_____Number of children born alive:_____Birth weights:_____

Did you have any problems with your pregnancies? ❒No ❒Yes:_____

Do you plan on becoming pregnant? ❒Yes ❒No

Do you use birth control? ❒No ❒Yes What method?_____

Are you still menstruating? ❒Yes ❒No If yes, date of last period:_____

Sexual Concerns:_____

For Men only:

Do you have any sexual concerns? ❒ No ❒ Yes *(If Yes, check all that apply:)*

❒difficulty getting / maintaining an erection ❒Sexual arousal ❒ Other_____

Have you had a PSA test (prostate specific antigen)? ❒No ❒Yes: Date:_____

Nutrition:

Have you ever seen a dietitian (RD) for diabetes? ❒Yes ❒No If yes, when?_____

Do you have a meal plan? ❒Yes ❒No

If Yes, how often do you follow it?

❒Always ❒ Most of the time ❒Sometimes ❒Rarely ❒Never

If you don't follow your meal plan, why not?_____

What **type of meal plan** do you follow? (Check all that apply)

❒Carbohydrate Counting ❒Calorie Counting Other_____

❒Low Salt ❒Exchange System

❒Low fat/cholesterol ❒Weight Watchers

What **time** do you **eat your meals**?

Breakfast_____ Do you eat snacks? ❒Yes ❒ No

Lunch_____ If yes, when?_____

Dinner_____

My meal times vary most days: ❒Yes ❒ No

Do you **skip meals**? ❒Yes ❒ No If yes, which meals?_____

Eating Out: How often do you eat out or bring home "take out"?

❒Never ❒3-5 times/week

❒Rarely ❒More than 5 times/week

❒1-3 times per week

Types of restaurants?

❒fast food ❒sit-down restaurants Other_____

❒buffets ❒sweets/coffee shops

How many people live in your household?_____ Ages:_____

Who cooks?_____ Who shops?_____

Do you have any **food intolerances** (such as lactose intolerance/spicy foods?) ❒Yes ❒ No

If yes, please list:_____

Have you **gained weight** over the past year? ❒Yes ❒ No

How much?_____

Have you **lost weight** over the past year? ❒Yes ❒ No

How much?_____

How do you feel about your weight right now?

_____

What do you think is a healthy weight for you? _____

As an adult, what has been: Your lowest weight?_____

Your highest weight?_____

Have you ever tried to lose weight with a diet or exercise? ❒Yes ❒ No

If ***yes***, please explain:

_____

Do you eat for reasons other than hunger? ❒Yes ❒No

If y***es***, in what types of situations? (parties, boredom, stress, at work, family gatherings, etc)

_____

Do you have certain foods that cause you to overeat? ❒Yes ❒No

If ***yes***, please list these foods

_____

Do you want to make changes in what you eat? ❒Yes ❒ No

If ***yes***, what type of changes?

_____

Is there anything you especially want to learn from the dietitian?

_____

_____

What are your expectations for attending this Diabetes training program?

_____

_____

Thank you for filling out this information.
It will help the dietitian and nurse in preparing your diabetes education plan.

Please bring this completed form to your Assessment appointment.