

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: Home: \_\_\_\_\_  
 City: \_\_\_\_\_ Work: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell / Other: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_

**MAY WE E-MAIL INFORMATION TO YOU?**  Yes  No

Physician Name: \_\_\_\_\_ Physician Address: \_\_\_\_\_

**Statistical Data:** Sex:  M  F Primary Language: \_\_\_\_\_  
**Marital Status:**  Single  Married / Partnered  Divorced  Widowed  
**Living:**  Alone  With others  
**Ethnic Group** (check all that apply):  African American / Black  Caucasian  Latino  
 Asian / Pacific Islander  Native American  Middle Eastern  Other (specify): \_\_\_\_\_  
**Employed:**  Yes  No  Retired What is / was your occupation? \_\_\_\_\_  
**Health Insurance:**  Yes  No Name of your health insurance? \_\_\_\_\_

The ways you learn best:	Barriers / Difficulties
<input type="checkbox"/> Discussion	<input type="checkbox"/> Visual _____
<input type="checkbox"/> Reading	<input type="checkbox"/> Hearing _____
<input type="checkbox"/> Lecture	<input type="checkbox"/> Reading / Writing _____
<input type="checkbox"/> Hands On	<input type="checkbox"/> Understanding what you read _____
<input type="checkbox"/> Video / TV / Computer	<input type="checkbox"/> Physical difficulties _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

**Your Diabetes Is:**  Type 1  Type 2  
 Gestational  Other \_\_\_\_\_  
 I don't know

**When Diagnosed:** \_\_\_\_\_ **Age at Diagnosis:** \_\_\_\_\_

**Do you have family with diabetes?**  Yes  No  
 If yes, who? \_\_\_\_\_  
 What type? \_\_\_\_\_

**Management of Diabetes:**  
 What do you use to manage your diabetes?  
 Diet  Exercise  Pills  Insulin  Other Injection  Other \_\_\_\_\_

**Were you taught to take care of diabetes?**  
 If yes, when? \_\_\_\_\_ Who taught you? \_\_\_\_\_

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**Nutrition:** Do you follow a food plan / diet?  Yes  No      Type of plan: \_\_\_\_\_

What do you drink for thirst? \_\_\_\_\_      Who cooks at home? \_\_\_\_\_

How many times a week do you eat fried foods?  
 Never       1 or 2 times a week       More than 2 times a week

How many times a week do you eat out? \_\_\_\_\_      Type of restaurant? \_\_\_\_\_

Do you eat breakfast or within 1-2 hours of waking up?  Yes  No

How many meals or snacks do you eat a day and at what times?  
 Meals #: \_\_\_\_\_ Times: \_\_\_\_\_      Snacks #: \_\_\_\_\_ Times: \_\_\_\_\_

<u>Typical Breakfast</u>	<u>Typical Lunch</u>	<u>Typical Supper</u>	<u>Typical Snack</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Alcohol:  Yes  No      Drinks per week: \_\_\_\_\_

What is your height? \_\_\_\_\_      What do you weigh? \_\_\_\_\_

What did you weigh last year? \_\_\_\_\_      What would you like to weigh? \_\_\_\_\_

If your weight changed in the last year, what is the reason? \_\_\_\_\_

**Exercise and Physical Activity:**

Do you exercise?  Yes  No      Regularly?  Yes  No      If yes, how many times / week? \_\_\_\_\_

How many minutes each time? \_\_\_\_\_      What type(s)? \_\_\_\_\_

Do you exercise:  alone       with someone?      With whom? \_\_\_\_\_

If you do not exercise, what it is the reason? \_\_\_\_\_

Do you have to limit your activities / exercise in any way?  Yes  No

If yes, please explain: \_\_\_\_\_

**Home Diabetes Testing:**

Do you test your blood glucose (sugar)?  Yes  No  
 How often? \_\_\_\_\_      Meter Name \_\_\_\_\_

Do you write down your results?  Yes  No  
 Usual results \_\_\_\_\_

What should your results be? \_\_\_\_\_

When do you test?  
 Before eating in the morning       Before meals  
 At bedtime       After meals  
 With exercise       Other times \_\_\_\_\_

What do you do with your used lancets / needles: \_\_\_\_\_

Did you ever have high blood glucose (high sugar)?  Yes  No  
 If yes, when / how did you take care of it? \_\_\_\_\_

Why did this happen? \_\_\_\_\_

Did you test urine for ketones?  Yes  No  
 If yes, did you have ketones?  Yes  No  
 or ketoacidosis?  Yes  No  
 If yes, how was it treated? \_\_\_\_\_

Did you ever have low blood glucose (low sugar)?  Yes  No  
 If yes, when / how did you take care of it? \_\_\_\_\_

Why did this happen? \_\_\_\_\_

**Medicines for Diabetes (pills)**

<u>Name</u>	<u>Dose</u>	<u>Time Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medicines for Diabetes (insulin or other injection)**

Name \_\_\_\_\_ Amount \_\_\_\_\_ When taken \_\_\_\_\_  
 Name \_\_\_\_\_ Amount \_\_\_\_\_ When taken \_\_\_\_\_

Who prepares the injections and gives the medicine? \_\_\_\_\_

How do you take your medicine? Using  Vial and syringes  Pen  Pump

Where (in your body) do you inject? \_\_\_\_\_ Where do you store the medicine? \_\_\_\_\_

After opening, how long do you keep the medicine? \_\_\_\_\_

Reuse syringes  Yes  No What do you do with your used syringes: \_\_\_\_\_

**Medicine for other conditions, prescription, over-the-counter and supplements: (Attach separate page, if needed.)**

<u>Name</u>	<u>Dosage</u>	<u>When Taken</u>	<u>What does it treat?</u>
_____	_____	_____	_____
_____	_____	_____	_____

**General Health: Food and Medication Allergies:** \_\_\_\_\_

Do you wear medical ID?  Yes  No

**Do you have any of these health problems (check all that apply)? Please give details.**

High blood pressure: \_\_\_\_\_ If yes, what is your average BP? \_\_\_\_\_

Heart disease \_\_\_\_\_ If yes, explain: \_\_\_\_\_

High cholesterol \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Thyroid disease \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Kidney / Bladder problems \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Eye / vision problems \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Foot problems \_\_\_\_\_ If yes, explain: \_\_\_\_\_ Last foot exam / Results \_\_\_\_\_

Numbness / pain \_\_\_\_\_ If yes, explain, including location: \_\_\_\_\_

Balance problems \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Frequent Infections \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

Sexual function problems \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Other medical problems \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Last flu vaccine: \_\_\_\_\_ Last pneumonia vaccine: \_\_\_\_\_ Last dental exam: \_\_\_\_\_

Last dilated eye exam / Results \_\_\_\_\_

**Hospitalizations (in the past year or related to diabetes), including dates / reasons** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tobacco:  Yes  No Type: \_\_\_\_\_ # per day: \_\_\_\_\_ When started: \_\_\_\_\_

If stopped tobacco use, when did you stop? \_\_\_\_\_

Recreational Drugs:  No  Yes Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**How do you rate your health?**       Poor     Fair     Good     Very Good     Excellent

**Please answer each of the following:**

I find it hard to believe that I really have diabetes.       Yes     No

Paying for diabetes care is a problem.       Yes     No

I have difficulty taking care of my diabetes.       Yes     No

I feel unhappy or angry because I have diabetes.       Yes     No

All things considered, I feel satisfied with my life.       Yes     No

Does your culture or religion influence your decisions about diabetes?  
(e.g. special foods / fasting or religious observances)       Yes     No

If yes, how? \_\_\_\_\_

Who is your support person(s) or who helps you? \_\_\_\_\_

How do you rate the level of stress / tension in your life?     Low     Moderate     High

What causes your stress? \_\_\_\_\_

How do you manage stress? \_\_\_\_\_

What worries you most about diabetes? \_\_\_\_\_

What are you most interested in learning during diabetes education? \_\_\_\_\_

Who will attend class? \_\_\_\_\_

**Participant's Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_

**PLEASE DO NOT WRITE BELOW THIS LINE**

**Educator Assessment Summary:** \_\_\_\_\_

Education Needs Identified:

All aspects of diabetes education: classes

All aspects of diabetes education: individual sessions: reason: \_\_\_\_\_

Individual education topics: \_\_\_\_\_

\*\*\*Refer to plan on education record\*\*\*

Educator Signature: \_\_\_\_\_      Date: \_\_\_\_\_

Educator Printed Name: \_\_\_\_\_

**Point of care:** Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_ B/P \_\_\_\_\_

Blood glucose \_\_\_\_\_ Time: \_\_\_\_\_ (fasting / non-fasting) HbA1c \_\_\_\_\_

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