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DIABETES CENTER

Please take a few moments to complete the following information **Date:**

Education	☐ Less than High School	☐ College Degree
	☐ High School/GED	☐ Trade/Vocational
	☐ Some College	☐ Advanced Degree

LEARNING

What method of learning do you prefer?	☐ Reading	☐ Lecture/Audio	☐ Hands On	☐ Video	☐ Group Discussion
Do you have any problems related to the following?	☐ None	☐ Vision Problems	☐ Language	☐ Difficulty Reading	
	☐ Memory Loss	☐ Denial of Diabetes	☐ Lack of Family Support	☐ Work Schedule	☐ Finances
	☐ Food Issues	☐ Unresolved Eating Disorder		☐ Grief	☐ Other

BLOOD GLUCOSE MONITORING

Do you check your blood glucose (blood sugar)?				☐ Yes	☐ No
If "Yes", what is the name of your blood glucose meter? *(please specify)*					
How often do you check your blood glucose (blood sugar)?		☐ 1X per day	☐ 2X per day	☐ 3X per day	☐4X per day
		☐ more than 4X per day	☐ Every Other Day	☐ Occasionally	☐ Rarely
What time of day do you monitor? *(Check all that apply)*	☐ Fasting	☐ Before Breakfast	☐ After Breakfast	☐ Before Lunch	☐ After Lunch
	☐ Before Dinner	☐ After Dinner	☐ Bedtime	☐ Other	

HYPERGLYCEMIA

Have you ever experienced hyperglycemia (blood sugar greater than 250 mg/dl)? (symptoms such as thirst, dry mouth, tiredness, frequent urination, or a blood sugar over 250 mg/dl on your glucose meter?				☐ Yes	☐ No
How often do you have	☐ 1 – 3X week	☐ 4 – 6X week	☐ 7 or more times a week	☐ Rarely	☐ Unknown

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hyperglycemia?						
What time of day do you have hyperglycemia?	☐ Fasting	☐ Before Breakfast	☐ After Breakfast	☐ Before Lunch	☐ After Lunch	☐ Before Dinner
	☐ After dinner		☐ Bedtime	☐ Other		
Have you ever been hospitalized for high blood sugar?					☐ Yes	☐ No
HYPOGLYCEMIA						
Have you ever had hypoglycemia (low blood sugar)? (symptoms such as sweating, anxiety, trembling, or headaches)					☐ Yes	☐ No
If "yes" how often do you have hypoglycemia?	☐ 1 – 3X week	☐ 4 – 6X week	☐ 7 or more times a week		☐ Rarely	☐ Unknown
How do you treat hypoglycemia?	☐ Juice	☐ Soda	☐ Milk		☐ Sugar	☐ Candy
	☐ Glucose Tabs	☐ Food	☐ Do Nothing		☐ Other	
Have you ever required help from others to treat low blood sugar?					☐ Yes	☐ No
Are you able to feel when your blood sugar is low?					☐ Yes	☐ No
What is your average fasting blood sugar?						
DIABETES SPECIFIC						
Does anyone in your family have diabetes?	☐ Mother	☐ Father			☐ Sibling	☐ Grandparent
	☐ Multiple Family Members				☐ None	☐ Other
Have you been through diabetes education in the past?					☐ Yes	☐ No
If "Yes", how long ago?	☐ less than 1 year	☐ 1 – 5 years	☐ 6 – 10 years		☐ More than 10 years	☐ Unknown
Have you been to the Emergency Room (ER) or admitted in the last 6 months?					☐ Yes	☐ No
MEDICAL HISTORY: Check all areas in which you have any problems or received medical treatment.						
Heart and Circulation	☐ Stroke	☐ Heart Failure	☐ Heart Disease	☐ High Blood Pressure		
	☐ Heart Attack	☐ Tingling, Numbness, or Pain in your Feet, Legs, or Hands		☐ Other		

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Teeth and Gums	☐ Periodontal Disease	☐ Tooth Loss	☐ Gingivitis	☐ Dental Abscess
	☐ Chronic Dry Mouth	☐ Mouth or Gum Lesions		☐ Other
Liver	☐ Cirrhosis	☐ "Fatty" Liver	☐ Hepatitis	☐ Liver Failure
	☐ Portal Hypertension		☐ Other	
Metabolism	☐ Celiac Disease	☐ Elevated Cholesterol	☐ Thyroid Disorder	☐ Metabolic Syndrome
	☐ Overweight/Obesity		☐ Polycystic Ovarian Syndrome (PCOS)	
Kidneys	☐ Dialysis	☐ End Stage Renal Disease	☐ Protein in Urine (proteinuria, macro- or micro-albuminuria	
	☐ Insufficient Kidney Function		☐ Kidney Transplant	☐ Other
Nervous System	☐ Bladder Control	☐ Constipation	☐ Diarrhea	☐ Digestion
	☐ Unable to Tell when Blood Sugar is Low		☐ Tingling, Numbness or Pain in your Feet, Legs or Hands	
	☐ Motor Control	☐ Sexual Function	☐ Dry, Cracked Skin	☐ Other
Eyes	☐ Cataracts	☐ Glaucoma	☐ Swelling of the Macula or Retina (Macular Edema)	
	☐ Diabetic Eye Disease (Retinopathy)		☐ Vision Loss/Legally Blind	☐ Other
Other	☐ Depression	☐ Sleep Apnea	☐ Reflux	☐ Other

MEDICATIONS

List your prescriptions and over-the-counter medications, including aspirin, vitamins, inhalers and herbal supplements.

Medication Name	How Much Do You Take?	When Do You Take the Medication?

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ALLERGIES TO MEDICATIONS AND FOODS	
Medication/Food Name:	**Reaction:**

INSULIN

Please complete this section if you currently use insulin

Where do you inject your	☐Abdomen	☐ Arm	☐ Buttocks	☐ Thigh	☐ Rotate sites	☐ Other

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insulin?						
Do you adjust your own insulin dose?					☐ Yes	☐ No
Do you have access to glucagon?					☐ Yes	☐ No

DIABETES MEDICAL MANAGEMENT **Please check any of the following assessments, exams, and vaccinations you have had and indicate the date**			
Exam:			**Date:**
Complete Physical Exam	☐ Yes	☐ No	
Dental Exam	☐ Yes	☐ No	
Dilated Eye Exam	☐ Yes	☐ No	
EKG/Stress Test	☐ Yes	☐ No	
Flu Vaccination	☐ Yes	☐ No	
Foot Exam by Physician	☐ Yes	☐ No	
Pneumonia Vaccination	☐ Yes	☐ No	

PERSONAL HEALTH HABITS				
Do you currently smoke?			☐ Yes	☐ No
If "yes", how much?	☐ less than 5/day	☐ ½ pack per day	☐ 1 pack/day	☐ More than 1 pack/day
Have you ever been referred to a program to help you stop smoking?			☐ Yes	☐ No
If "yes", how long ago and what type of program?				

Do you drink alcohol? ☐ Yes	☐ No	**If "Yes", how much?**	
☐ less than 1 drink/day	☐ 1 – 2 drinks/day	☐ more than 3 drinks/day	☐ Social Occasions

MEALS AND DINING		
Do you skip meals?	☐ Yes	☐ No
Do you have a Gluten Tolerance?	☐ Yes	☐ No

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Do you have Gastroparesis?					☐ Yes	☐ No
Do you have any food allergies or intolerances?					☐ Yes	☐ No
If "yes", please specify:						
Do you have any cultural or religious dietary practices?					☐ Yes	☐ No
If "yes", please specify:						
Who is responsible for your meal preparation?	☐ Self	☐ Spouse	☐ Self & Spouse	☐ Family	☐ Significant Other/Self	
	☐ Child	☐ Friend	☐ Parent(s)	☐ Grandparent(s)	☐ Group Home	
	☐ Assisted Living		☐ No One	☐ Other		
Who is responsible for buying your groceries?	☐ Self	☐ Spouse	☐ Self & Spouse	☐ Family	☐ Significant Other/Self	
	☐ Child	☐ Friend	☐ Parent(s)	☐ Grandparent(s)	☐ Group Home	
	☐ Assisted Living		☐ No One	☐ Other		
How often do you eat out?	☐ Daily	☐ 4 – 6 X/week		☐ 1 – 3X/week	☐ Rarely	
	☐ Every other week		☐ Occasionally	☐ Never		

PHYSICAL ACTIVITY

Do you participate in regular physical activity or exercise?					☐ Yes	☐ No
If "Yes", what type?	☐ Aerobics	☐ Biking	☐ Cardiac Rehab	☐ Combination	☐ Running	☐ Sports/Athletics
	☐ Stretching	☐ Swimming	☐ Walking	☐ Weights	☐ Other	
How long are you active?	☐ less than 10 minutes	☐ 10 – 20 minutes	☐ 21 – 30 minutes	☐ 31 – 40 minutes	☐ 41 – 50 minutes	☐ more than 50 minutes
How often are you active?		☐ less than once a week	☐ 1 -2 X/week	☐ 3 – 5X/week	☐ 6 – 7Xweek	☐ more than 7Xweek
How would you rate the activity?			☐ Easy	☐ Moderate	☐ Difficult	☐ Strenuous
Do you have any physical limitations that prevent you from being physically active?					☐ Yes	☐ No
If "yes", please specify:						

SELF FOOT-CARE

Do you examine your feet?				☐ Yes	☐ No
If "Yes", how	☐ Daily	☐ Every other day	☐ Occasionally	☐ Rarely	

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often?					
Do you have any problems with your feet?	☐ None	☐ Callus(es)	☐ Bunions	☐ Neuropathy	☐ Ulcer
	☐ Fungal toenail(s)		☐ Structural Deformity	☐ Other (please specify)	

FEMALE SPECIFIC RELATED TO PREGNANCY (IF CHILDBEARING)

Are you planning to become pregnant?	☐ Yes	☐ No
Are you aware of the effects of diabetes on pregnancy and of pregnancy on diabetes?	☐ Yes	☐ No
Have you ever been pregnant?	☐ Yes	☐ No
If "yes", how many times?	**How many live births?**	

SELF- ASSESSMENT

How would you rate your current understanding of diabetes?		☐ Good	☐ Fair	☐ Poor
How would you rate your overall health?		☐ Good	☐ Fair	☐ Poor
How would you rate your stress level?		☐ High	☐ Medium	☐ Low
How do you handle stress?	☐ Exercise	☐ Hobbies	☐ Meditation	☐ Spiritual
	☐ Music	☐ Other		
Does diabetes interfere with anything in your life? *(check all that apply)*	☐ Nothing	☐ Family/Social Activities		☐ Sports/Exercise
	☐ Work/School	☐ Sexual Relations	☐ Finances	☐ Travel	☐ Other
Do you have any religious, cultural, or personal health beliefs that effect your diabetes?			☐ Yes	☐ No
If yes, please explain:				

PAIN

Do you have any ongoing problems with pain?	☐ Yes	☐ No
If yes, please explain:		
Are you having pain right now?	☐ Yes	☐ No

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If yes, please rate your pain right now: 0 1 2 3 4 5 6 7 8 9 10 None Most Pain		
DIABETES IDENTIFICATION		
Do you carry an ID that states you have diabetes?	☐ Yes	☐ No

What is your long term goal for attending this diabetes education program?

- ☐ Learn more about diabetes
- ☐ Improve my blood sugar control
- ☐ Help with meal planning
- ☐ Learn more about carbohydrate counting
- ☐ Help with weight management
- ☐ Learn more about insulin administration
- ☐ Other:

Is there any other information you would like to discuss with us?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM