Hartford HealthCare
The Hospital of Central Connecticut

Patient Name: _____

Date of Birth: _____

HOCC/MIDSTATE DIABETES AND NUTRITION CENTER PRE-EVALUATION

Please take a few minutes to complete the following information. Thank you.

Date: _____

OVERVIEW:					
What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Pre Diabetes ☐ Don't Know					
How many years have you had diabetes? ☐ Less than 1 year ☐ 1- 10 years ☐ Greater than 10 years					
Have you had previous education on how to take care of your diabetes? ☐ Yes ☐ No					
LEARNING:					
Education ☐ Less than high school ☐ High School/GED ☐ Some College ☐ College Degree ☐ Trade/Vocational ☐ Advanced Degree					
What method of learning do you prefer? ☐ Reading ☐ Lecture/Audio ☐ Hands On ☐ Video ☐ Group					
Do you have any problems related to the following? ☐ None ☐ Vision ☐ Hearing ☐ 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 or continuous glucose monitor (CGM)?					
How often do you check your blood glucose (blood sugar)?		☐ Once/day	☐ Twice/day	☐ 3Xday	☐4X/ 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	

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HYPOGLYCEMIA (low blood sugar):					
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 per week?	☐ 1 – 3X	☐ 4 – 6X	☐ 7 or more time	☐ Rarely	☐ Unknown
How do you treat hypoglycemia?	☐ Juice	☐ Soda	☐ Milk	☐ Sugar	☐ Candy
	☐ Glucose Tabs	☐ Food	☐ Do Nothing	☐ Other	

MEDICAL HISTORY:			
☐ Stroke	☐ Heart Attack	☐ Elevated cholesterol	☐ High Blood Pressure
☐ Erectile Dysfunction	☐ Sleep Apnea	☐ Kidney Disease	☐ Thyroid Disorder
☐ Cancer	☐ Depression	☐ Other:	

MEDICATIONS: PLEASE LIST YOUR DIABETES MEDICATIONS.		
Medication Name	**How Much Do You Take?**	**When Do You Take the Medication?**

Please list any vitamins, minerals, or supplements you take:

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

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DIABETES MEDICAL MANAGEMENT: **In the last 12 months, please indicate whether you have had the following:**		
Dilated Eye Exam	☐ Yes	☐ No
Foot Exam	☐ Yes	☐ No
Emergency room visits related to diabetes	☐ Yes	☐ No
Inpatient admissions related to diabetes	☐ Yes	☐ No
Flu Vaccination	☐ 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

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 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

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	☐ 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	
Do you currently follow any type of meal plan? (Examples: low calorie, low carb, carb counting, low cholesterol, low sodium, or vegetarian)				☐ Yes	☐ No
Please list what types of foods or beverages do you typically snack on? (Examples: fruit, chips, crackers, cookies, pretzels, popcorn, sandwiches, soda, etc.)					
Do you drink soda?	☐ Yes ☐ No		☐ Regular ☐ Diet	If yes: How many cups or ounces per day?	
Do you drink:	☐ Caffeinated coffee ☐ Caffeinated tea ☐ Energy drinks			If yes: How many 8oz cups per day?	
	☐ Water			If yes: How many 8oz cups per day?	

24 HOUR FOOD RECALL: PLEASE LIST WHAT YOU ATE AND DRANK YESTERDAY OR A TYPICAL DAY

BREAKFAST: _____

SNACK: _____

LUNCH: _____

SNACK: _____

DINNER: _____

SNACK: _____

Within the past 12 months:	I worried whether my food would run out before I/we had money to buy more ☐ Yes ☐ No
	The food purchased did not last and I/we did not have money to buy more ☐ Yes ☐ No

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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 1x/week	☐ 1-2 x/week	☐ 3-5 x/week	☐ 6-7 x/week	☐ More than 7x/week	

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

From whom do you get support for your diabetes? ☐ Family ☐ Friends ☐ Co-workers ☐ Health Care Providers ☐ Support Group ☐ No one ☐ Other_____

What information would you like to receive at your visit today?

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OTHER:		
Do you use computers/smart phones to: ☐ Text or send emails ☐ Look for health or other information		
How much help did you need to complete this form? ☐ None ☐ A little ☐ A lot ☐ Someone filled out for me		
DIABETES IDENTIFICATION:		
Do you carry an ID that states you have diabetes?	☐ Yes	☐ No

PLEASE DO NOT WRITE BELOW THIS LINE

Education Needs/Education Plan:

□ Diabetes Disease Process □ Nutritional Management □ Physical Activity □ Monitoring
□ Preventing Acute Complications □ Preventing Chronic Complications □ Risk Reduction Strategies
□ Behavior Change Strategies □ Psychosocial Adjustment □ Alcohol guidelines
□ Smoking cessation □ Preconception

Clinician Signature: _____ **Date:** _____