

DIABETES EDUCATION INITIAL ASSESSMENT FORM

PATIENT INFORMATION

Name:	Age:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
Home Phone:	Alternate phone:
Email Address:	
Race: <input type="checkbox"/> White <input type="checkbox"/> White/Hispanic <input type="checkbox"/> Non-white Hispanic <input type="checkbox"/> Black/Hispanic <input type="checkbox"/> Black/African American, <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Biracial/Multiracial <input type="checkbox"/> Other, Unknown, Unspecified	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Other:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Last grade of school completed: <input type="checkbox"/> Less than High School <input type="checkbox"/> High School/GED <input type="checkbox"/> Trade/Vocational <input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Advanced Degree	
Occupation: <input type="checkbox"/> Manual labor <input type="checkbox"/> Professional <input type="checkbox"/> Self-Employed <input type="checkbox"/> Homemaker <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Trade/Vocational <input type="checkbox"/> Disabled <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	
Hours worked per week: <input type="checkbox"/> <20 <input type="checkbox"/> 20-40 <input type="checkbox"/> >40 <input type="checkbox"/> N/A	
Shift: <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Rotating	
Primary support person: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Child <input type="checkbox"/> Parent(s) <input type="checkbox"/> Other:	
Primary caretaker: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Child <input type="checkbox"/> Parent(s) <input type="checkbox"/> Assisted Living <input type="checkbox"/> Other:	
Living Arrangements: <input type="checkbox"/> Self <input type="checkbox"/> Self & Spouse <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Self & Significant Other <input type="checkbox"/> Child <input type="checkbox"/> Parents <input type="checkbox"/> Other:_____	
Learning Preference: <input type="checkbox"/> Computer <input type="checkbox"/> Reading <input type="checkbox"/> Listening/Audio <input type="checkbox"/> Hands on Demonstration <input type="checkbox"/> Video <input type="checkbox"/> Group Discussion <input type="checkbox"/> No Preference	
Would you like to receive emails from our department about future education programs and services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
MEDICAL HISTORY	
What type of diabetes do you have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Gestational <input type="checkbox"/> Don't know	
How long have you had diabetes? _____ Years _____ Months	
Does anyone in your family have diabetes? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Child/Children <input type="checkbox"/> Multiple family members <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other:	
Have you had diabetes education in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> < 1 month ago <input type="checkbox"/> 1-3 months ago <input type="checkbox"/> 4-6 months ago <input type="checkbox"/> 7-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> 6-10 years ago <input type="checkbox"/> > 10 years ago <input type="checkbox"/> Unknown	
Have you met with a dietitian (nutritionist) in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> < 1 month ago <input type="checkbox"/> 1-3 months ago <input type="checkbox"/> 4-6 months ago <input type="checkbox"/> 7-12 months ago <input type="checkbox"/> 1-2 years ago <input type="checkbox"/> 3-5 years ago <input type="checkbox"/> 6-10 years ago <input type="checkbox"/> > 10 years ago <input type="checkbox"/> Unknown	
If so, what was the reason for the visit with the dietitian?	



DeKalb Medical Physicians Group
Nutrition and Diabetes Education Center

DIABETES EDUCATION INITIAL ASSESSMENT FORM

Page 1 of 5

DMC FORM # PS-1089 (12/09/15)



P 5 - 1 0 8 9

DIABETES EDUCATION INITIAL ASSESSMENT FORM

In the past 12 months, have you been a patient in an emergency room? Yes No

In the past 12 months, have you been admitted to a hospital? Yes No

If yes, was the emergency room visit or hospital admission related to your diabetes? Yes No

Has your weight changed over the past year? Yes No

If yes, please describe how: _____

Have you ever tried to change your weight? Yes No

If yes, please describe in what way and how successful you were: _____

- | | | |
|-------------------------------------------------|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Teeth/Gum problems |
| <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma/Bronchitis/COPD | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Acid Reflux/GERD |
| | | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Anxiety/Depression |
| | | <input type="checkbox"/> Other: |

Female Specific:

Do you have your period? Yes No If yes, when was your last menstrual cycle? Date: _____

Do you use birth control? Yes No If yes, what type: _____

Are you considering getting pregnant in the future? Yes No

Pregnancy History: Number of pregnancies: _____

Number of live births: _____

Number of babies born weighing more than 9 pounds: _____

Have you had Gestational Diabetes or baby weighing 9 pounds or more in the past? Yes No

Have you had a Hysterectomy? Yes No

Are you post-menopausal? Yes No

MEDICATIONS

Medication Name	How much?	How often?	When?



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Nutrition and Diabetes Education Center

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P 5 - 1 0 8 9

DIABETES EDUCATION INITIAL ASSESSMENT FORM

Do you have any allergies to medications? No Don't know Yes: list here

Do you ever forget to take your medications? No Yes If yes, why? _____

How many times per week do you miss a medication? Never < 1 x per week 1 x per week
 2-3 x per week 4-6 x per week 7 or more x per week

If you take insulin, which parts of your body do you use to inject? Arm Thigh Abdomen
 Buttocks Other: _____

Where do you store your insulin? Room temperature Refrigerator Other: _____

Blood Sugar Monitoring

Do you check your blood sugar? Yes No

What type of meter do you have?

How often do you check your blood sugar? 1 x per day 2 x per day 3 x per day 4 x per day
 > 4 x per day Every other day Occasionally, rarely

What time of day do you check your blood sugar? Fasting Before breakfast After breakfast
 Before lunch After lunch Before dinner After dinner Bedtime 12 am 3 am
 Random Other

Have you ever experienced hyperglycemia or high blood sugar (symptoms such as thirst, dry mouth, tiredness, frequent urination)? Yes No

How often do you have hyperglycemia? 1-3 x per week 4-6 x per week 7 or more x per week
 Rarely Unknown

What time of day do you experience hyperglycemia? Fasting Before breakfast After breakfast
 Before lunch After lunch Before dinner After dinner Bedtime 12 am 3 am
 Random Other

Have you ever been hospitalized for high blood glucose? Yes No

Have you ever had hypoglycemia or low blood sugar (symptoms such as sweating, anxiety, trembling, headaches)? Yes No

How often do you have hypoglycemia? 1-3 x per week 4-6 x per week 7 or more x per week
 Rarely Unknown

What time of day do you have hypoglycemia? Fasting Before breakfast After breakfast
 Before lunch After lunch Before dinner After dinner Bedtime 12 am 3 am
 Random Other

How do you treat hypoglycemia? Juice Soda Milk Sugar Candy Glucagon
 Glucose tabs Food Do nothing Other



DeKalb Medical Physicians Group
Nutrition and Diabetes Education Center

DIABETES EDUCATION INITIAL ASSESSMENT FORM

Page 3 of 5

DMC FORM # PS-1089 (12/09/15)



P 5 - 1 0 8 9

DIABETES EDUCATION INITIAL ASSESSMENT FORM

Medical Management

In the past year, which of the below have you done? Complete physical exam Foot exam Dental exam
 Dilated eye exam Stress test Flu vaccination Pneumonia vaccination Hepatitis B vaccination
 Routine 3 month diabetes visit

Self-Care Behavior

Do you drink alcohol? Yes No If yes, how often? Less than one drink per day 1-2 drinks per day
 3 or more drinks per day Social occasions

Do you use recreational drugs? Yes No

Do you carry or wear diabetes identification? Yes No

Do you participate in regular physical activity/exercise? Yes No

Do you exercise for more than 150 minutes per week? Yes No

What type of exercise do you do? Aerobics Biking Cardiac rehab Combination Running
 Sports/Athletics Stretching Swimming Walking Weights
 Other

How often do you exercise? < 1 per week 1-2 x per week 3-4 x per week
 5-6 x per week 7 or more x per week

How long do each of your exercise sessions last? < 15 minutes 15-30 minutes 31-45 minutes
 46-60 minutes > 60 minutes

How would you rate the activity? Easy Moderate Difficult Strenuous

Do you have any physical limitations that prevent you from exercising? Yes No
If yes, please explain:

How would you rate your current understanding of diabetes? Good Fair Poor

How do you feel about diabetes? Acceptance Adaptation Anger Denial Fear Guilt
 Overwhelmed/Confused Sadness/Depression

How would you rate your overall health? Good Fair Poor

How important is your health to you? Extremely Somewhat Only when ill Not important

How would you rate your stress level? High Medium Low

Does diabetes interfere with anything in your life? Family/Social Activities Work/School
 Sports/Exercise Sexual Relations Finances Travel Nothing Other

Do you examine your feet? Yes No

If yes, how often? Daily Every other day Occasionally Rarely

Do you have any foot problems? Callus (es) Bunions Neuropathy Ulcer Fungal toenail(s)
 Structural deformity None Other

Do you have a history of tobacco use? Yes No If yes, approximate quit date:

Do you currently smoke? Yes No

How much? Occasionally < 5 per day ½ pack per day ¾ pack per day 1 pack per day
 > 1 pack per day



DeKalb Medical Physicians Group
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DIABETES EDUCATION INITIAL ASSESSMENT FORM

Page 4 of 5

DMC FORM # PS-1089 (12/09/15)



P 5 - 1 0 8 9

DIABETES EDUCATION INITIAL ASSESSMENT FORM

Meal Plan

Do you follow a specific meal plan? Yes No If yes,

1. What kind? _____

2. How well do you follow your meal plan? 100% 75% 50% 25% <25%

Do you skip meals? Yes No

Who is responsible for preparing your meals? Self Spouse Both self & spouse Family
 Significant other Child Friend Parent In-home support Neighbor Other: _____

Who is responsible for buying your food? Self Spouse Both self & spouse Family
 Significant other Child Friend Parent In-home support Neighbor Other: _____

How often do you eat out? Daily 4-6 x per week 1-3 x per week Every other week
 Occasionally Never

Are you allergic or unable to tolerate certain foods? Yes No If yes, please explain:

Do you have any cultural or religious dietary practices? Yes No If yes, please explain:

Breakfast (Time: _____:_____)

Morning Snack: (Time: _____:_____)

Lunch (Time: _____:_____)

Afternoon Snack: (Time: _____:_____)

Dinner (Time: _____:_____)

Bedtime Snack: (Time: _____:_____)

Fluids:

Patient Signature: _____ Date: _____ Time: _____

Diabetes Educator Signature: _____ Date: _____ Time: _____



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DIABETES EDUCATION INITIAL ASSESSMENT FORM

Page 5 of 5

DMC FORM # PS-1089 (12/09/15)



P 5 - 1 0 8 9