DIABETES EDUCATION INITIAL ASSESSMENT FORM

PATIENT INFORMATION

Name:	Age:
Sex: ☐ Male ☐ Female	Date of Birth:
Home Phone:	Alternate phone:
Email Address:	

Race: ☐ White ☐ White/Hispanic ☐ Non-white Hispanic ☐ Black/Hispanic ☐ Black/African American,
☐ American Indian/Alaskan Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro
☐ Samoan ☐ Other Pacific Islander ☐ Biracial/Multiracial ☐ Other, Unknown, Unspecified

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ French ☐ Other:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Last grade of school completed: ☐ Less than High School ☐ High School/GED ☐ Trade/Vocational
☐ Some College ☐ College Degree ☐ Advanced Degree

Occupation: ☐ Manual labor ☐ Professional ☐ Self-Employed ☐ Homemaker ☐ Retired
☐ Unemployed ☐ Student ☐ Trade/Vocational ☐ Disabled ☐ Unknown ☐ Other:

Hours worked per week: ☐ < 20 ☐ 20-40 ☐ > 40 ☐ N/A
Shift: ☐ Day ☐ Evening ☐ Night ☐ Rotating

Primary support person: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Other:

Primary caretaker: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Assisted Living
☐ Other:

Living Arrangements: ☐ Self ☐ Self & Spouse ☐ Family ☐ Friend ☐ Self & Significant Other ☐ Child
☐ Parents ☐ Other:_____

Learning Preference: ☐ Computer ☐ Reading ☐ Listening / Audio ☐ Hands on Demonstration
☐ Video ☐ Group Discussion ☐ No Preference

Would you like to receive emails from our department about future education programs and services?
☐ Yes ☐ No

MEDICAL HISTORY

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Gestational ☐ Don't know

How long have you had diabetes? _____ Years _____ Months

Does anyone in your family have diabetes? ☐ Mother ☐ Father ☐ Brother/Sister ☐ Grandmother
☐ Grandfather ☐ Child/Children ☐ Multiple family members ☐ None ☐ Unknown ☐ Other:

Have you had diabetes education in the past? ☐ No ☐ Yes If yes, ☐ < 1 month ago ☐ 1-3 months ago
☐ 4-6 months ago ☐ 7-12 months ago ☐ 1-2 years ago ☐ 3-5 years ago ☐ 6-10 years ago
☐ > 10 years ago ☐ Unknown

Have you met with a dietitian (nutritionist) in the past? ☐ No ☐ Yes If yes, ☐ < 1 month ago
☐ 1-3 months ago ☐ 4-6 months ago ☐ 7-12 months ago ☐ 1-2 years ago ☐ 3-5 years ago
☐ 6-10 years ago ☐ > 10 years ago ☐ Unknown

If so, what was the reason for the visit with the dietitian?

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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: _____

Do you have any of the following?

☐ Eye Disease	☐ Kidney Disease	☐ Teeth/Gum problems	☐ Numbness/tingling
☐ Heart Problems	☐ High Blood Pressure	☐ High Cholesterol	☐ Asthma/Bronchitis/COPD
☐ Liver Disease	☐ HIV/AIDS	☐ Cancer	☐ Stomach Problems
☐ Thyroid Disorder	☐ Acid Reflux/GERD	☐ Anxiety/Depression	☐ Arthritis
☐ Sexual Problems	☐ Sleep Apnea	☐ Other:	

Female Specific:

Do you have your period? ☐ Yes ☐ No If yes, when was your last menstral 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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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

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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)

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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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