Dignity Health
St. Rose Dominican

Place Patient Identification Label Here

Today's Date: ______/_______/______
Visit start _________ **end** __________ **time**
Total minutes___________ **Initials**________
Educator to complete

Diabetes Patient Health Assessment Form

Personal Information

Name ____
(Last) (First) (M.I.)

Address ____
(Street #) (City) (State) (Zip)

Phone # ____________________ Cell # ___________________ Best time to contact________________

Email Address________________________ Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity: ☐White ☐ Black ☐ Hispanic, Latino or Spanish ☐ Asian ☐ American Indian or Alaskan Native
☐ Middle Eastern or North African ☐ Native Hawaiian or Other Pacific Islander

How did you hear about our diabetes program? ____

Referring Provider _________________________ Primary Care Provider ___________________________

Are you currently employed? Y / N What is your occupation? ________________Work days/hours: ___________

How many people live in your household? ___________ Financial barrier to diabetes care? ☐Yes ☐ No

What is your language preference ☐ English ☐ Other ____

Years of schooling completed? _____ How long have you had diabetes? _____ Age of onset ________

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What type of diabetes do you have? ☐ pre-diabetes ☐ type 1 ☐ type 2 ☐ gestational ☐ do not know

In your own words, what is diabetes? ____

Rate your understanding of diabetes? ☐ Good Fair ☐Poor

Have you ever met with a diabetes educator? Yes No , If yes, when/where? __________________

What would you like to learn about your diabetes? ____

How do you feel about your diabetes? ____

Who assists with diabetes care? ____

List relatives (living or deceased) with diabetes.____

For office use

Goals for today's visit:____

____

____

____

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Diabetes History

What is the name of your blood glucose monitor? ______________ How old is your monitor? _______________

☐ I do not have a blood glucose monitor ☐ I would like a new blood glucose monitor

Do you check your blood sugars? Yes No Blood sugar readings range between ___________&__________

How often: ☐ Once daily ☐ 2 or more daily ☐ One or more per week ☐ Occasionally

When do you check your blood sugar: fasting before meals two hours after meals bedtime

during the night feeling unusual symptoms other ____

What is your target range before meals? ____________________ After meal range? _______________________

What was your most recent hemoglobin A1C? _______ date ________ Your goal A1C level?_______________

What was the date and result of your last blood pressure reading? ____

What are symptoms of a low blood sugar?____________________and explain how treat? ___________________

Have you had a severe high blood sugar over 240 in the past month? Yes No When?_____How high?_____

Have you had a severe low blood sugar below 70 in the past month? Yes No When?_____ How low?_____

Check the diabetes medication you take for diabetes and list the total dosage

Medication Name	Dosage/Quantity	Medication Name	Dosage/Quantity
☐ Actos (pioglitazone)		☐ Micronase (glyburide)	
☐ Amaryl (glimepiride)		☐ Nesina (alogliptin)	
☐ Avandia (rosiglitazone)		☐ Onglyza (saxagliptin)	
☐ Byetta/Bydureon (exendtide)		☐ Prandin (repaglinide)	
☐ Cycloset (bromocriptine)		☐ Precose (acarbose)	
☐ Glucophage (metformin)		☐ Starlix (nateglinide)	
☐ Glucotrol (glipizide)		☐ Symlin (pramlintide)	
☐ Glyset (miglitol)		☐ Tanzeum (albiglutide)	
☐ Farxiga (dapagliflozin)		☐ Tradjenta (linagliptin)	
☐ Januvia (sitagliptin)		☐ Trulicity (dulaglutide)	
☐ Jardiance (empagliflozin)		☐ Victoza (liraglutide)	
☐ Invokana (canagliflozin)		☐ WelChol (colesevelam)	
☐ Other:		☐ Other	

If you are on insulin, what type and amount do you take at the following times?

Breakfast:________________ Lunch:________________Dinner:________________Bedtime:_________________

Do you inject your insulin with: ☐ Syringe ☐ Insulin pen ☐ Insulin pump ☐ Do you take inhaled insulin?

List other medications, vitamins or supplements you take:____

____

How often do you miss taking your medication as prescribed? ☐ never ☐ daily ☐ weekly ☐ monthly

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Nutrition and Lifestyle History

Your height? _______Current weight? _______Weight change in # over last 3 months? ____________________

Do you want to lose weight? Yes No What is your desired weight range?______________ BMI _________

Have you seen a dietitian for a meal plan? Yes No If yes, when? ________________________________

Do you have any food allergies or food restrictions?____

How many meals do you eat daily?__________________How many snacks do you eat each day?_____________

How many times during a week do you eat away from home? ____

List any cultural/religious diet restrictions you follow, if any: ____

Please fill in the times of your meals, snacks, and any diabetes medications you are taking below. Also include examples of the type and amount of food you might eat for your meals and snacks.

TIME	Portion size	MY TYPICAL MEALS AND SNACKS	Beverages
I get up at: ________ Meal time: ________ Diabetes pill/insulin: ________		**Breakfast Food Consumed:**	
Snack time: ________		Morning snack foods:	
Meal time: ________ Diabetes pill/insulin: ________		**Lunch Food Consumed:**	
Snack time: ________		Afternoon snack foods:	
Meal time: ________ Diabetes pill/insulin: ________		**Dinner Food Consumed:**	
Snack time: ________ Diabetes pill/insulin: ________ I go to bed at: ________		Evening/bedtime snack foods:	

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Activity

Do you exercise? ☐ Yes ☐ No Where do you exercise? ___________________________________

If yes, what type(s)? ☐ Walking ☐ Bicycling ☐ Aerobic Machine ☐ Swimming ☐ Other: _________________

How many times per week do you exercise? 0 1-2 3-4 5-6 More than 6

How many minutes per time? 0 1-10 11-15 16-29 More than 30

My exercise routine is: ☐ easy ☐ moderately intense ☐ very intense

Have you ever been advised by a physician to limit your exercise in any way? ☐ No ☐ Yes

If yes, please explain: ____

Medical History

Do you have any of the following? eye problems hearing problems difficulty speaking dental problems kidney problems numbness/tingling/loss of feeling in your feet high blood pressure sexual problems high cholesterol or triglycerides difficulty remembering depression other, please explain_____________

____

Do you have any other medical problems? ____

____

Recent surgeries, please list: ____

In the past year, how many times have you seen your physician or health care provider?

none 1 2 3 4 5 6 or more

In the past year, how many times have you gone to the emergency room or been admitted to the hospital?

none 1 2 3 4 5 6 or more briefly explain__________________________

When was your last eye exam?______________________When was your last dental exam?_________________

When was your last foot exam? ____________________________ Do you check your feet daily? Yes No

How many cigars/cigarettes/chewing tobacco products do you use a day? _____________week? _____________

How many times in a week do you drink alcohol, beer or wine 0 1 2 3 4 5 6 7

Diabetes and Emotions

Rate your desire/level of motivation to change your eating/exercise habits? Lowest * 1 2 3 4 5 * Highest

How do you learn best? ☐ listening ☐ reading ☐ observing ☐ doing ☐ other______________________________

How do you handle stress? ____

What do you find most difficult about caring for your diabetes?_______________________________________

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Diabetes and Emotions continued

What is your greatest fear about having diabetes? ____

Have you been feeling sad/depressed? Y / N

Do you often feel tired? Y / N Do you have trouble sleeping or do you sleep too much? Y / N

Have you been gaining or losing weight without trying? Y / N

Do you often feel agitated or like you can barely move? Y / N

Do you have trouble making decisions or concentrating on your work? Y / N

To be completed by pregnant or prospective pregnant patients only:

Are you planning to become pregnant? Yes / No Do you have children? Yes, their ages___________/ No
Are you pregnant? Yes, estimated delivery date:_______________ / No
How many pregnancies in the past? ___________, How many live births?___________________________________
Are you aware of the impact of diabetes on pregnancy? Yes / No, Current weight ______Pre-pregnancy weight ________
Labs: 1 hour glucose screen date: _________, results:__________mg/dl
Oral glucose tolerance test date: ________, results: Fasting:_____, One hr:_____, Two hr:______, Three hr:_______

For office use:

Diabetes Educator Assessment Overview

☐Reviewed DM ed book

Education Topics discussed:

☐Diabetes disease process ☐Nutritional Management ☐Physical Activity ☐Using Medications
☐Monitoring ☐ Preventing Acute Complications ☐Preventing Chronic Complications
☐Behavior Change Strategies ☐Risk Reduction Strategies ☐Psychosocial adjustment
☐Goal Setting/Problem solving

GOALS: Suggested CHO/meal: BG range: (-) A1c%:

☐ Healthy eating	☐ Monitoring
☐ Activity	☐ Problem solving
☐ Medications	☐ Healthy coping
Risk reduction: ☐ acute	☐ chronic

Diabetes Educator Signature: ___________________________________Date: ___________

Follow-up: ____________ Classes: ______________________