Personal Information

Name _____ DOB _____ Age _____ Sex: M / F
(first / last) (month/day/year)

Address _____ _____ _____ _____
street, apt # city state zip

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Education Completed: ☐ Grade School ☐ High School ☐ Some College ☐ College Graduate

From whom do you get support for your diabetes? ☐ Family ☐ Co-Workers/Friends ☐ Healthcare Providers ☐ No One
☐ Other_____

Special needs:

☐ Visually Impaired ☐ Deaf ☐ Interpreter (language) _____ ☐ Other needs _____

Do you need help understanding written medical directions? ☐ Yes ☐ No

Do you have cultural, religious or health beliefs that influence how you take care of your diabetes? _____

Medical History (check all that apply)

My General Health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Numbness/Tingling (☐Feet / ☐ Hands)
☐ Dry Skin/Other Skin Problems
☐ Slow Healing Wounds
☐ Kidney Problems/Urinary Tract Infections
☐ Sexual Dysfunction
☐ Sleep Apnea/Snoring
☐ Vision Problems/Loss of Sight
☐ Reflux/Digestion Problems
☐ Thyroid Problems
☐ Other Hormone/Endocrine Problems
☐ Diabetes Related to Pregnancy
☐ Family Members with Diabetes
☐ High Cholesterol
☐ High Blood Pressure
☐ Heart Problems
☐ Other_____
_____

Diabetes History

Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Pre-Diabetes ☐ Don't know ☐ Other _____

Year of Diagnosis _____What concerns you most about your diabetes?_____

What is the most difficult part for you in caring for your diabetes? _____

Have you ever received diabetes education with a nurse or dietitian? ☐ Yes ☐ No
If yes, where/year_____

How do you learn best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing

Are you ready to make changes for diabetes care? ☐ Almost Ready ☐ Ready ☐ Already Working on Changes
☐ Met Goals & Trying to Maintain

My goals for this visit today are: _____

_____

OVER →

PLEASE LIST ALL MEDICATIONS YOU TAKE ON A DAILY BASIS:

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Current Diabetes Treatment: ☐ None ☐ Diet & Exercise ☐ Oral Diabetes Medication ☐ Injections

How much Insulin do you take: Before breakfast _____ Before Lunch _____

Before Supper _____ At Bedtime _____

Problems/Side Effects from medications? _____

Do you have **low blood sugars**? ☐ Never ☐ Infrequently ☐ Weekly ☐ Daily

Do you have any concerns about your ability to afford treatment? _____

Blood Glucose Testing Frequency

How often do you check blood sugar? _____

Name/Brand of Blood Glucose Meter _____ Year Obtained _____

Range of Blood Sugar _____ _____
low high

Physical Activity Do you exercise regularly? ☐ Yes ☐ No If yes, type _____

Duration _____ Frequency _____ Intensity: ☐ Light ☐ Medium ☐ Heavy
(amount of time) (number days per week)

Nutrition Height _____ _____ Weight _____ My weight goal is: _____
feet inches
Do you currently follow a meal plan? ☐ Yes ☐ No If yes, what kind _____

Risk Factors

Do you smoke? ☐ Yes ☐ No If yes, how long? _____ years Packs per day_____

Do you drink alcohol? ☐ Yes ☐ No If yes, number of drinks per day _____ per week _____

Time: _____ **Date:** _____ **Patient signature:** _____

Diabetes Education Needs (office use only)

☐ Disease Process & Treatment Options	☐ Medication Use	☐ Healthy Coping
☐ Nutritional Management	☐ Monitoring Blood Glucose	☐ Problem Solving
☐ Physical Activity	☐ Complications	☐ All of the above

Time: _____ **Date:** _____ **Reviewed by Diabetes Educator:**_____

Living Will/Advance Directive

Do you have a Living Will or Advance Directive for healthcare? ☐ Yes ☐ No
(not applicable if less than 18 years of age)

If you answered no, would you like a written document of a Living Will/Advance Directive? ☐ Yes ☐ No

Domestic Violence

Have you ever been hit, kicked, punched, strangled or threatened? ☐ Yes ☐ No

If yes, when? _____

Do you feel unsafe at home, at risk for injury or neglect by persons in your household or those who help provide for your care? ☐ Yes ☐ No

If yes, when? _____

_____

Time: _____ Date: _____ Patient signature: _____

Time: _____ Date: _____ Reviewed by: _____

Action Taken:

_____

_____

_____

_____

_____