PATIENT INITIAL ASSESSMENT-DIABETES

Name: ______________________________ Date: ______________
Address: ______________________________
Phone: Home (____)______________ Work: (____)______________ Mobile: (____)__ __________
Date of Birth: ___/___/___ Age: _____ Gender: ___F___M Weight_________ Height________ Weight Goal_______
Ethnic Background: White/Caucasian___ Black/A-A ___ Hispanic ___ Native American___ Middle-eastern___

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Marital Status: Single___ Married___ Divorced___ Widowed___ Significant other____
Number in household:____ How are they related to you? ______________________
I get support for my diabetes from: Family _____ Co-workers____ Health care providers____ Support Group _____
No one____ other_____

2. Currently employed? N_____ Y_____ Occupation? ______________ Work hrs: __________
Primary Language: English______ Other ______________ Highest grade completed? __________
Need Assistance with: Visual______ Hearing____ Reading_____ Physical Limitation:______ Other:__________

3. What type of diabetes do you have? Type 1____ Type 2____ Pre-diabetes____ GDM____ Don't Know____
Year/Age of Diabetes Diagnoses:_______/_________ Relatives with diabetes: ______________
What is diabetes? ______________________ Previous diabetes education: N___ Y___

4. Do you take diabetes medications? N____ Y_____ which one/s: Diabetes pills____ Insulin injections____
Byetta injections_____ Symlin injections_____ Combination of pills and injections_________
Have you forgotten to take your diabetes medications?: N____ Y ____ What do you do? __________
If you take insulin: Where do you store it? ____________ Inject it? __________ Dispose of it?______
Who gives injection? ______________ Method: syringe_____ insulin pen______ insulin pump________
Do you reuse syringes? N_____ Y______ Do you have a sliding scale? N_____ Y_____ (provide copy)

5. Do you check your blood sugars? N___Y____ 2 or more/day___ 1 or more/Week___ Other__________
When: Before breakfast____ 2 hours after meals____ Before bedtime____ Other__________
Results: before meal________ after meal________bedtime________ Do you keep a record: N____ Y_____

6. How often have you had a low or high blood sugar in the last 3 months:
Low blood sugar: how often?: ______________ Time of day__________ At what number?__________
Symptoms? ______________________ Treatment? ______________
Do you have a glucagon kit? N__ Y__ If you've used it, When? ______________
High blood sugar: how often? ______________ Time of day__________ At what number?__________
Symptoms? ______________________ Treatment? ______________
Wear a medical ID? N____ Y____ Test for ketones? N___Y____ When? ______________

7. Do you have?: eye problems____ kidney problems_____ numbness/tingling/loss of feeling in feet___ heart disease____

8. Do you smoke: N___Y___ What ? ______________ How many? __________ How long? __________
Do you drink alcohol? N___ Y___Type: ______________ How many_____x per week or month
Caffeine N___ Y___ What? ______________ How much? ______________
Do you exercise regularly? N___ Y____ Type: ______________ How Often: __________
My exercise routine is: easy________ moderately________ intense________ very intense__________
Problems with exercise: ______________________

9. Your medical conditions: High blood pressure___ High Cholesterol___ High triglycerides____ Allergies________
dental problems___ sexual problems___ depression___ Other______________________

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Are you planning a pregnancy? N___ Y___ When? ____________________
Previously pregnant? N___ Y____ How many times?______ Do you have children? N___ Y___Ages: __________
Are you aware of the impact of diabetes on pregnancy? N_____ Y_____ Are you using birth control? N___ Y____

10. How often do you see a doctor for? Eye exam______________ Glasses/contact lenses?________________
dental exam____________ Routine diabetes visit__________ Foot care______________ other________________
Hospital stays in the last year:_________________________ Emergency room____________________________
Last Lab Results: Blood Sugar:__________ HgbA1C:__________ Chol:__________HDL:__________Trig:__________
Blood Pressure:__________ Date: __________

11. Please state whether you agree, are neutral or disagree with the following statements:
I feel good about my general health: agree___ neutral___ disagree___
My diabetes interferes with other aspects of my life: agree___ neutral___ disagree___
My level of stress is high: agree___ neutral___ disagree___ How do you handle it?______________________
I have some control over whether I get diabetes complications or not: agree___ neutral___ disagree___
I struggle with making changes in my life to care for my diabetes: agree___ neutral___ disagree___
What is the most difficult thing about having diabetes?____

12. List a learning Goal: (Purpose for today's visit)

____

How do you learn best: Listening_____ Reading_____ Observing_____ Doing _____

13. Do you have any cultural/ religious practices or beliefs that influence how you care for your diabetes? N___ Y___
Please explain:

____

14. Do you have a meal plan for diabetes? N___Y___ If yes, describe: ______________________________
Who shops for your food?_____________ Who prepares your food?_____________
I eat fried foods_____x / wk or month Diet restrictions: Salt___ Fat___ None___ Other ___________
My portions are: small____ average____ large_____ I eat: Slow_____ Average_____ Fast_____
Moods or stress: increases my eating_____ decreases my eating_____ none___ symptoms for hunger:___________
Meals consumed per day:________ Snacks per day:___________ What kind:_________________________
Vitamin Supplements? Yes ___ No ___ List: ____
Skip meals? N___ Y_____ which one/s:____
I eat desserts: _____x / day or week, list:____
How often do you eat out? ______________List type restaurant/fast food: ___________________________

Give a sample of your meals for a typical day: Indicate portions.... 1/2 cup, 1 slice, 1 teaspoon, etc.

Time: ________ Breakfast: ____

____

Time: ________ Lunch: ____

____

Time: ________ Dinner: ____

____

Time: ________ Snack:____

Time: ________ Snack: ____

Time:________ Snack:____