Sacred Heart Health System

PATIENT INFORMATION

Name: _____ DOB: _____ Date: _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Race: ☐ Asian ☐ African American/Black ☐ Caucasian/White ☐ Hispanic ☐ Middle Eastern
☐ Other: _____ ☐ Do not know
Number of people living in your household: _____ Who helps with your diabetes care: _____
Occupation: _____ Highest school grade completed: _____
Primary Doctor: _____ Diabetes Doctor: _____
Email Address: _____
Who referred you to Diabetes Education? ☐ MD ☐ Other: _____

DIABETES HISTORY

1. How long have you had diabetes? _____
2. What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Do not know
3. List any family members with diabetes: _____
4. In your own words, what is diabetes? _____
5. Rate your understanding of diabetes: ☐ Good ☐ Fair ☐ Poor
6. Have you ever been instructed on diabetes: ☐ Yes ☐ No If yes, when & by whom: _____
7. What are your fears about having diabetes: _____
8. My diabetes has caused problems in the following areas:
   ☐ Family Life ☐ Work/School ☐ Sports/Exercise ☐ Sexual Relations ☐ Finance
9. How do you learn best: ☐ Written Materials ☐ Verbal Discussion ☐ Video
10. What is your goal (s) for this education session: ☐ Learn more about diabetes ☐ Meal planning
    ☐ Better blood sugar ☐ How to test blood sugars ☐ Use of insulin ☐ Other _____
11. Identify any barriers that may prevent you from receiving adequate healthcare: _____
    _____

MEDICATION

1. Do you take medication (s) for your **diabetes**? ☐ Yes ☐ No If yes, list the name (s) **and** amount (s):
   _____
   _____
2. Have you ever forgotten to take your diabetes medication (s)? ☐ Yes ☐ No If yes, what did you do: _____
3. If you take insulin, how do you give it? ☐ Bottle & syringe ☐ Pens ☐ Pump

MONITORING *(Please bring your blood sugar meter with you to this appointment)*

1. Do you test your blood sugar? ☐ Yes ☐ No
2. How many times per day do you test your blood sugar? _____
3. Usual blood sugar in the morning: _____ in the afternoon: _____ in the evening: _____
4. What is your most recent A1C? _____ Date: _____
5. If you have type 1 diabetes, do you test your urine for ketones? ☐ Yes ☐ No

EXERCISE

1. Do you exercise regularly? ☐ Yes ☐ No
2. Describe your exercise routine: _____
3. List any problems with exercise: _____

ACUTE COMPLICATIONS

1. Have you ever had a low blood sugar? □ Yes □ No If yes, how did/do you treat it: _____
2. How many times per week do you have a low blood sugar? _____
3. Do you carry a source of sugar with you? □ Yes □ No
4. What do you consider a healthy blood sugar range? _____

CHRONIC COMPLICATIONS

1. Are you aware of complications that may develop with diabetes? □ Yes □ No
2. Do you have any of the following complications due to having diabetes- **Please Check**
   □ Eye problem □ Heart problems □ Kidney problems □ GI problems
   □ Numbness/pain □ Sexual problems

MEDICAL HISTORY

1. List **other medical condition** (s) you are being treated for besides diabetes **and** medications you are taking for these conditions: _____
   _____
   _____
   _____
2. Do you have your eyes checked yearly? □ Yes □ No
3. Do you wear glasses or contact lenses? □ Yes □ No
4. Have you noticed any changes in your skin? □ Yes □ No If yes, describe: _____
5. Do you check your feet: □ Daily □ Several times weekly □ 1-2 times monthly □ Not at all
6. How often do you go to the dentist? _____
7. Do you smoke? □ Yes □ No If yes, how much **daily**: _____
8. Do you drink alcohol? □ Yes □ No If yes, how much **per week**: _____
9. Have you been in the hospital within the last 6 months? □ Yes □ No If yes, describe: _____
   _____
10. Do you wear a medical identification bracelet or necklace? □ Yes □ No
11. How would you rate your general health: □ Good □ Fair □ Poor

STRESS

1. Do you currently have ongoing stress in your life? □ Yes □ No If yes, explain: _____
   _____
2. How do you cope with stress? _____

CULTURAL INFLUENCES

1. Do you have any special dietary needs or religious observances? □ Yes □ No
2. Your preferred language to speak and write: _____

NUTRITION

1. Height: _____ Weight: _____ what weight do you feel best at? _____
2. Have you gained weight in the last 6 months □ Yes □ No
   Have you lost weight in the last 6 months □ Yes □ No
3. Have you ever had nutrition counseling? □ Yes □ No
4. Do you skip meal **regularly**? □ Yes □ No
5. Do you eat vegetables **daily**? □ Yes □ No
6. Do you eat fruit **daily**? □ Yes □ No
7. Do you eat second helpings of food? □ Usually not □ Occasionally □ Most times
8. List any **food** allergies: _____

9. How often do you dine out **per week**? □ Less than once □ 1-2 times □ 3 or more
10. Do you snack? □ Yes □ No If yes, how many times per day: _____
11. Write down what you typically eat for meals & snacks: **include beverages**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Patient, please do not write below this line

To be completed by Diabetes Educator (s)

Please check all that apply:

□ Diabetes Disease Process	□ Nutrition Management	□ Physical Activity
□ Using Medication(s) Safely	□ BG Monitoring	□ Acute Complications
□ Chronic Complications	□ Psychosocial Issues	□ Behavior Change

Educator Signature: _____ Date: _____

Educator Signature: _____ Date: _____

Sacred Heart Health System