

Diabetes Assessment Record

I. PATIENT INFORMATION

Name _____ Age _____ Race _____ Sex: Female Male Date _____

E-mail address: _____

Marital status: S M W D Level of education _____ Occupation _____ Work hours _____

Physician's name _____ Participant status: Inpatient Outpatient

II. GENERAL MEDICAL CONDITION

Lab test date: _____ A₁C _____ Total cholesterol _____ Triglycerides _____ HDL _____ LDL _____

Height _____ Current weight _____ Usual weight _____ Desired weight _____ Weight changes in past year: ↑

↓ _____

Allergies _____

Other medical problems _____

Present health status: Excellent Good Fair Poor

III. DIABETES HISTORY

Type of diabetes: Type I Type II Medication-induced _____

Duration of diabetes _____

Treatment plan: Insulin Other injectables (Byetta, Symalin) Oral medications Diet & exercise alone

Name of insulin/injectable _____

Units of insulin _____ at _____ times. Units of insulin _____ at _____ times.

Name of diabetes pill _____ Dosage _____ at these times _____

Other

medications _____

List concerns regarding your medications _____

Blood sugar monitoring: Test times _____

Type of meter _____ Usual results: Fasting _____ After meals _____ Times _____

a. Do you ever have low blood sugar (hypoglycemia)? Yes No

b. What are your signs of low blood sugar? _____

c. How often does it occur and what time of day? _____

d. How do you treat a low blood sugar? _____

Do you have a problem with?

Feet _____

Vision _____

Wound healing _____

Sensation _____

Kidneys _____

Heart _____

IV. DIETARY HABITS

Do you follow a special diet? Yes No Type of diet _____
 Indicate times of: Breakfast _____ Lunch _____ Dinner _____ Snacks _____
 Do you skip meals? Yes No If yes, how often? _____
 Do you eat out often?: Yes No If yes, how often? _____ Where? _____
 Do you do your own grocery shopping? Yes No If no, who does? _____
 Who does the cooking at your house? _____
 _____ Do you drink alcohol? Yes No
 If yes, type and amount. _____
 Describe any weight loss experience or program you may have had?

 What topics about meal planning and food would be the most helpful? _____

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V. PHYSICAL ACTIVITY HABITS

How would you rate your energy level? Low Low/Moderate Moderate Moderate/High High
 Do you have a regular exercise program (20 minutes, 3 days a week)? Yes No If yes, indicate below.

<u>Type</u>	<u>Length of time</u>	<u>Intensity</u>	<u>Frequency</u>
_____	_____	<input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	
_____	_____	<input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	

Do you have any problems or conditions that restrict your activity (knee/hip/back pain, arthritis, retinopathy, recent surgery, etc.)? Yes No
 Has your physician placed any restrictions on your activity (no lifting, etc.)? Yes No

VI. DIABETIC EDUCATION HISTORY

Prior diabetes education? Patient: Yes No Significant other(s): Yes No
 When _____ Where _____
 Will significant others participate in program? Yes No
 Do you have problems reading? Yes No
 Do you have problems hearing? Yes No
 Other:

VII. SOURCE OF REFERRAL

Physician Self-referral Facility staff Community agent Other _____

VIII. PSYCHOSOCIAL HISTORY

Cigarettes per day _____ Alcoholic drinks per week _____ Type _____
 Number of people living in your household _____ Relationship _____
 How has diabetes affected your life? _____

Do you travel often? Yes No If yes, where and length of visits? _____

IX. GOALS

What do you hope to learn or gain from these classes/sessions? (Examples: Weight loss, meal plan/exchange system, workable exercise plan, blood glucose monitoring.)

- a. _____
 - b. _____
 - c. _____
 - d. _____
-

NUTRITION HISTORY

Name _____ **Age** _____ **Height** _____ **Weight** _____

Please complete the area below and indicate how you are currently eating. Record how you typically eat -- not what you think you should be eating. Be sure to include the exact type and amount of foods eaten. If your intake varies a lot between weekdays and weekends, give an example of each type of day.

Example: Mashed potatoes -- 1/2 cup and roast beef -- 2 oz.

	Day 1		Day 2	
Meal times	Food items (be specific)	Amount Eaten	Food items (be specific)	Amount Eaten
Breakfast time				
Snack time				
Lunch time				
Snack time				
Dinner time				
Snack time				