



*The American Diabetes Association Recognizes this education service as meeting the National Standards for Diabetes Self-Management Education.

DIABETES ASSESSMENT RECORD



Please complete this form and bring it with you.

1. PATIENT INFORMATION

Date: _____

Name: _____ Age: _____ Race: _____ Marital status: (circle) S M W D

Gender: (circle) M F

Level of education: _____ Occupation: _____ Work hours: _____

Physician's name: _____

2. DIABETES HISTORY

Type of diabetes: (check) Type 1 _____ Type 2 _____ Pre-diabetes _____ Do you have a family history of diabetes? Yes _____ No _____

How long have you had diabetes? _____ Blood Sugar when diagnosed _____

Treatment and Medication(s): DIET & EXERCISE ALONE _____

| Oral Diabetes Medication(s) | Dose | Time Taken |
|-----------------------------|------|------------|
| | | |
| | | |
| | | |

| Injectable Diabetes Medication(s) | Dose | Time Taken |
|-----------------------------------|------|------------|
| | | |
| | | |
| | | |

Do you have a blood sugar meter: Yes _____ No _____ If yes, what is the name? _____

How often or when do you test your blood sugars? _____ Typical Readings _____

Have you ever felt like you have experienced a low blood sugar? Yes _____ No _____

If yes, what symptoms do you have? and how do you treat? _____

3. GENERAL MEDICAL CONDITION(S)

Present health status: (circle) Excellent Good Fair Poor

Date: _____

Total cholesterol _____ LDL: _____ HDL: _____ Triglycerides: _____

A_{1c}: _____ Date: _____ Eye Exam Date: _____

Blood Pressure: _____

Allergies: _____

Other medical problems: _____

Other medications: _____

List surgeries and/or hospitalizations in the past year _____

Do you Smoke? Yes _____ No _____

4. EXERCISE/ACTIVITY

Do you exercise? Yes _____ No _____

If yes, what type(s) (circle)? Walking Bicycling Aerobic Machine Swimming Sports Other _____

How many times per week do you exercise? _____ For how many minutes each time? _____

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

What are your physical limitations which prevent you from exercising? _____

5. DO YOU HAVE A PROBLEM WITH ANY OF THE FOLLOWING? (please explain)

_____ Wound healing _____ Vision _____

_____ Kidney _____ Sensation _____

_____ Feet _____ Heart _____

_____ Sexual Function _____ Other _____

Who checks your feet? Self _____ Significant Other _____

How many times per week do you check your feet? _____

6. DIABETIC EDUCATION HISTORY

Prior diabetes education? Yes _____ No _____

When: _____ Where: _____

Will significant others participate in this program? No _____ Yes _____ Who _____

Do you have problems reading? Yes _____ No _____ Do you have problems hearing? Yes _____ No _____

Other: _____

7. SOCIAL HISTORY

Number in household: _____ Relationship: _____

How has diabetes affected your life? _____

8. GOALS

What do you hope to learn or gain from the classes? (Examples: lose weight, meal plan/exchange system, workable exercise plan, blood glucose monitoring)

1. _____

2. _____

9. WHAT ELSE WOULD YOU LIKE US TO KNOW ABOUT YOU? _____

NUTRITION HISTORY

Height: _____ Weight: _____ *Weight changes in the last year?* Increased Weight _____ Decreased Weight _____

1. Describe any prior weight loss experiences and/or programs you may have had: _____

2. Do you skip meals? Yes _____ No _____ Which meals? _____ How often? _____
3. Do you do your own grocery shopping? Yes _____ No _____
4. Who does the cooking at your house? Self _____ Spouse _____ Other _____
5. Do you eat out? Yes _____ No _____ How often? _____ Where? _____
6. Do you drink alcohol? Yes _____ No _____ Type and amount: _____ How often? _____

In the space provided, record what you typically eat including type and amount of food.

| <i>Example:</i> | <i>Cereal-Cheerios - 1 Cup</i> | <i>Milk - Skim - 1 Cup</i> | <i>Toast - 2 slices</i> |
|--------------------------|--------------------------------|----------------------------|-------------------------|
| Meal Times | Food Eaten and Amount | | |
| Breakfast Time: _____ | | | |
| Snack Time: _____ | | | |
| Lunch Time: _____ | | | |
| Snack Time: _____ | | | |
| Dinner Time: _____ | | | |
| Snack Time: _____ | | | |



CENTER FOR DIABETES
& NUTRITIONAL HEALTH

8601 W. Dodge Rd., Ste. 30
Omaha, NE 68114-3495

From the North

Take 90th Street to West Dodge Road and take a left
Take West Dodge Road to 87th Street and take a right
Go straight until you come to your first left (turn left)
Go about one block to the middle of the 8601 West
Dodge Road building

From the South

Go North on 90th to West Dodge Road and take a right
Take West Dodge Road to 87th Street and take a right
Go straight until you come to your first left (turn left)
Go about one block to the middle of the 8601 West
Dodge Road building

From the East

Take West Dodge Road to 84th Street and take a left
Take your immediate right (by the Durham Center Sign)
Take a left at the sixth drive
Go straight to front of the 8601 West Dodge Road
building
Then take a right and go to the middle of the building

From the West

Take West Dodge Road to 87th Street and take a right
Go straight until you come to your first left (turn left)
Go about one block to the middle of the 8601 West
Dodge Road building

