Beaumont

ADULT DIABETES ASSESSMENT

GENERAL INFORMATION

NAME	DATE
ADDRESS (street, city, zip code)	
BIRTHDATE	AGE
PREFERRED PHONE NUMBER (including area code) ☐ Home ☐ Cell ☐ Work (_____)_____	
EMAIL	
RACE ☐ Black/African American ☐ White ☐ Hispanic ☐ Asian ☐ Native American ☐ Other _____	
MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Single	

What is your occupation?_____

Shift normally worked: ☐ Days ☐ Afternoons ☐ Midnights

Highest level of education completed:

☐ Grade School ☐ High School ☐ College ☐ Post-Grad ☐ Other

Primary language spoken: _____ Primary language read: _____

Do you have a history of diabetes in your family? ☐ Yes ☐ No If yes, whom?: _____

Have you ever been hospitalized for diabetes? ☐ Yes ☐ No

If yes, please explain: _____

When were you diagnosed with diabetes?: _____ Which type? ☐ Type 1 ☐ Type 2 ☐ Don't know

How do you currently manage your diabetes?

☐ Meal plan ☐ Exercise ☐ Pills/other medications ☐ Insulin ☐ Self-monitoring blood glucose

Do you have any other medical conditions? ☐ Yes ☐ No

If Yes, please explain: _____

Have you ever had surgery? ☐ Yes ☐ No

If Yes, please explain: _____

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DIABETES KNOWLEDGE

Have you had diabetes education in the past? ☐ Yes ☐ No

Where and when? _____

How would you rate your understanding of diabetes?

☐ Excellent ☐ Good ☐ Average ☐ No Understanding

DIABETES KNOWLEDGE cont'd

What areas of diabetes would you like to learn more about? (check all that apply)

- ☐ Diabetes overview
- ☐ Medications
- ☐ Monitoring of blood glucose
- ☐ Meal planning/nutrition
- ☐ Insulin Pump therapy/ continuous glucose monitoring
- ☐ Physical activity/impact on blood glucose levels
- ☐ Behavior changes/goal setting
- ☐ Psychosocial adjustment
- ☐ Acute and chronic complications (prevent,detect,treatment)

How do you learn best? (check all that apply)

☐ Lecture/discussion ☐ Demonstration ☐ Film/TV ☐ Reading ☐ Hands on

What other information would you like to have to help you manage your diabetes?

_____

MEDICATIONS

Please list all your medications including over the counter, herbal preparations, vitamins, and other supplements

Medication Name	Dose / Time(s) Taken	Medication Name	Dose / Time(s) Taken

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:_____

MONITORING

Do you test your blood glucose? ☐ Yes ☐ No

Name of meter _____ How often?_____

Average results (the range from low to high)_____

Do you keep a record of your results? ☐ Yes ☐ No

NUTRITION HISTORY

Height _____ Weight _____ Goal weight _____

Have you had a recent weight change? ☐ No ☐ Gained ☐ Lost

How much gained or lost? _____ pounds in the past _____ months

Was this expected? ☐ Yes ☐ No

Do you have any of the following problems? ☐ Food allergies ☐ Frequent diarrhea ☐ Constipation

☐ Reflux ☐ Trouble chewing/swallowing ☐ Other _____

Have you ever followed a special diet? ☐ Yes ☐ No If yes, please describe:_____

_____

NUTRITION HISTORY cont'd

How often do you eat out in restaurants or eat fast food/take out?_____

What type of restaurants? _____

Do you skip meals? (check all that apply) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

How many average servings do you eat per day of the following: ☐ Fruit _____ ☐ Vegetables _____

☐ Whole grains _____ ☐ Legumes _____ ☐ Dairy _____ ☐ Protein/meat _____

How often do you drink alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Which type? ☐ Wine ☐ Beer ☐ Mixed alcoholic drinks ☐ Other _____

List meal and snack times and typical meals including beverages (like milk and juice) that you might have.

Time:_____ Breakfast: _____

_____

Time:_____ Lunch:_____

_____

Time:_____ Dinner:_____

_____

Time:_____ Snacks: _____

_____

EXERCISE

Do you exercise? ☐ Yes ☐ No If yes, please describe below:

TYPE	HOW OFTEN	HOW LONG

Is your exercise/activity limited by health problems? ☐ Yes ☐ No

If yes, how? _____

How often do you experience hypoglycemia when you exercise? _____

HYPOGLYCEMIC REACTIONS (Low blood glucose reactions)

Have you ever had a low blood glucose reaction? ☐ Yes ☐ No How often?_____

How do you treat a low blood glucose reaction? _____

What is your glucose source?_____

Do you live alone? _____ Or with? _____

Does your family/significant other know how to treat a low blood glucose reaction? ☐ Yes ☐ No

Do you have glucagon at home? ☐ Yes ☐ No

Do you carry diabetes identification? ☐ Yes ☐ No

If yes, what kind? ☐ Card ☐ Bracelet ☐ Necklace ☐ Other _____

HEALTH HABITS

Do you smoke or use any type of tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes (or other products) per day? _____

Do you use nicotine vaping products? ☐ Yes ☐ No If yes, frequency_____

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, what kind? _____ How often?_____

Date of last eye exam:_____ Date of last dental exam:_____

Date of last foot/monofilament exam:_____

Did you get the Hepatitis B vaccine? ☐ Yes ☐ No

Do you get yearly flu vaccines? ☐ Yes ☐ No

Did you get the pneumonia vaccine? ☐ Yes ☐ No

Do you examine your feet daily? ☐ Yes ☐ No

Do you currently have any of the following symptoms?

☐ Blurred vision ☐ Sexual problems ☐ Feeling of tiredness/weakness

☐ Any sores that will not heal ☐ Personality/mood changes

☐ Numbness or tingling in the hands/feet ☐ Unexpected change in appetite/weight

Do you have any problems related to diabetes? ☐ Yes ☐ No

If yes, please indicate: ☐ Eyes ☐ Heart ☐ Kidneys ☐ Circulation ☐ Other_____

PSYCHOSOCIAL

When you were first told you had diabetes, how did you feel about it? _____

_____

Describe how you feel about it now? _____

_____

What is the hardest thing for you when dealing with diabetes? _____

_____

What are your goals for Diabetes Education? _____

_____

Is there anything about your culture/religion that could affect how you manage your diabetes/diet?

☐ Yes ☐ No If yes, describe: _____

Other comments/concerns:_____

_____

_____

Patient Signature: _____ Date:_____

RN/RD Signature: _____ ID#: _____ Date:_____

Time of appointment: _____ Total time: _____