## ADULT DIABETES ASSESSMENT

### GENERAL INFORMATION

<table>
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<tr>
<th>NAME</th>
<th>DATE</th>
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<tr>
<td>ADDRESS (street, city, zip code)</td>
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<table>
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<tr>
<th>BIRTHDATE</th>
<th>AGE</th>
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**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

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

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose / Time(s) Taken</th>
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<th>Dose / Time(s) Taken</th>
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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:

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<th>TYPE</th>
<th>HOW OFTEN</th>
<th>HOW LONG</th>
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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 _______________________________________

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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: _______________