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Initial Diabetes Assessment

To help us meet your needs, please fill out this entire form to the best of your ability, and be sure we receive it **at least 3 business days** before your consult appointment so we can prepare for your visit.

Please print legibly. Completed by Patient Other _____

General Information

Name: _____ Today's date: _____

Male Female Birthdate: _____ Age: _____ Appointment date: _____

Who referred you to our practice? _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Marital Status: Single Married Widowed Separated Divorced

Spouse or Parent Name: _____ With whom do you live? _____

Your employer: _____ Occupation: _____

What hours do you work? _____ Highest education level achieved: _____

Have you ever seen a dietitian? No Yes. If yes, where and when? _____

Have you ever seen a diabetes educator? No Yes If yes, where and when? _____

Have you ever seen an endocrinologist? No Yes If yes, who and when? _____

Possible barriers to learning: Vision Hearing Literacy Memory None

Does any person help you with your diabetes care? No Yes. If yes, who? _____

My Diabetes History

When was your diabetes diagnosed? _____ When you were first diagnosed, what was your blood sugar? _____ Were you having symptoms? No Yes. If yes, explain _____

Diabetes type: Type 1 Type 2 Don't know

Do you use insulin? No Yes. If yes, when did you first start on insulin? _____

How would you describe your recent blood sugar control?

Excellent Good Fair Poor Don't know

Do you wear a diabetes medical identification emblem (necklace or bracelet)? No Yes

Are you a member of the American Diabetes Association (membership benefits include receiving *Diabetes Forecast* magazine)? No Yes

My Diabetes Medications

Please bring all medicine bottles with you

Insulin: Insulin pump (please complete separate “Insulin Pump Patient Questionnaire”)

Mark here if using insulin pen



	Units before breakfast	Units before lunch	Units before supper	Units before bedtime
Insulin (long-acting) <input type="checkbox"/> Pen <input type="checkbox"/> Lantus <input type="checkbox"/> Levemir <input type="checkbox"/> Toujeo				
Insulin (rapid-acting) <input type="checkbox"/> Pen <input type="checkbox"/> Humalog <input type="checkbox"/> Novolog <input type="checkbox"/> Apidra				
Insulin (other type) <input type="checkbox"/> Pen <input type="checkbox"/> _____				

Diabetes Pills: Mark “Past” (no longer taking) or “Present” (currently taking)

Past	Present		Dose (mg)	Time(s) of day	Started (year)
<input type="checkbox"/>	<input type="checkbox"/>	Glyburide	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glipizide	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glipizide XL	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glimepiride	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Metformin	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Metformin ER	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Actos (pioglitazone)	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Januvia	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Onglyza	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tradjenta	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Nesina	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Invokana	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Farxiga	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Jardiance	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Precose	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Welchol	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cycloset	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Combo pill (specify)	_____	_____	_____

Diabetes Injections (Non-Insulin): Mark “Past” (no longer taking) or “Present” (currently taking)

Past	Present		Dose (mg)	Time(s) of day	Started (year)
<input type="checkbox"/>	<input type="checkbox"/>	Byetta	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Victoza	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bydureon	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tanzeum	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Trulicity	_____	_____	_____

All other medications (prescription & non-prescription) that you currently take:

	Drug Name	Dose (mg)	When taken (times of day)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____
13.	_____	_____	_____
14.	_____	_____	_____
15.	_____	_____	_____

Please list any medications (prescription and non-prescription) that you are **allergic** to, or have had **side effects** from: None

Drug Name	Describe allergy or side effect
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy:

Mail order: _____ Preferred
 Local: _____ Preferred

My Nutrition

In the last few years, what has been your highest weight? _____ (When? _____)

In the last few years, what has been your lowest weight? _____ (When? _____)

Your current height? _____ Your current weight? _____

Please check any of the following that apply to your meal planning:

- Use exchanges Count calories Count carbohydrates
 Measure foods Weigh meats

Who does most of your food preparation at home? _____

How many times per week do you typically eat out at restaurants? _____

How many times per week do you typically eat "take out" meals? _____

What three restaurants do you eat at (or take out from) most often?

1. _____ 2. _____ 3. _____

How many ounces of sugar-sweetened beverages (such as sweet tea, regular sodas, and fruit juice) do you drink per day? _____ ounces, or none

Please list a typical day's food and beverage intake:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

Nutrition questions you would like answered: _____

My Exercise

Do you exercise? No Yes. If yes, what type(s) of exercise? _____

I exercise about _____ times per week for about _____ minutes each time.

What time of day do you exercise? _____

I would say the intensity of my exercise is mild moderate vigorous

Exercise questions you would like answered: _____

Monitoring My Diabetes

Please bring your blood glucose meter with you to each visit

Do you test your blood sugars? No Yes. If yes, how often? _____ times per day.

Meter: OneTouch Ultra 2 Accu-Chek Aviva FreeStyle Lite Other: _____
 OneTouch Verio IQ Accu-Chek Nano Bayer Contour

Do you keep a written record of results? No Yes Do you download results? No Yes

Current meter averages (as displayed): 7 days: _____ 14 days: _____ 30 days: _____

What is your typical range of blood sugar results?

Before breakfast: _____ After breakfast: _____

Before lunch: _____ After lunch: _____

Before supper: _____ After supper: _____

Bedtime: _____

My A1c usually runs about: _____. My most recent A1c was: _____ on (date) _____.

Hypoglycemia

On your current diabetes medicines, do you ever have hypoglycemia (low blood sugar or insulin reaction) symptoms? No Yes.

If so: How often? _____

Any particular time of day? _____

Typical low blood sugar symptoms: _____

Typical low blood sugar treatment: _____

Do you have trouble recognizing when your blood sugar is too low? No Yes

Have you ever had a severe low blood sugar episode (needing help)? No Yes

Diabetes Complications

Do you have any long-term complications from your diabetes (such as eye, kidney or nerve damage; heart problems or stroke; or foot problems) that you know about? No Yes

If so, please explain:

When was your last eye exam? _____ Eye doctor name: _____

Do you see a podiatrist (foot doctor)? No Yes. If yes, who? _____

Other Health History

Do you smoke? Never did Quit (when? _____) Yes

At what age did you start smoking? _____ Now smoke _____ packs per day.

Do you drink alcohol? No Yes. If so, what do you drink? How much? How often?

Do you use recreational drugs? No Yes. If so, what do you use? How much? How often?

Please list any other past or current medical problems: None

1.

9.

2.

10.

3.

11.

4.

12.

5.

13.

6.

14.

7.

15.

8.

16.

Please list any surgeries (and estimated dates): None

1.

4.

2.

5.

3.

6.

Primary care provider: _____

Please list any other doctors you see: None

1.

4.

2.

5.

3.

6.

Symptom Checklist

I am pregnant or may be pregnant

Please check and explain any symptoms you have had recently:

<p>General</p> <ul style="list-style-type: none"><input type="checkbox"/> Appetite increase<input type="checkbox"/> Appetite decrease<input type="checkbox"/> Weight loss<input type="checkbox"/> Weight gain<input type="checkbox"/> Excessive thirst<input type="checkbox"/> Fatigue (tired)<input type="checkbox"/> Unexplained fevers<input type="checkbox"/> Heat intolerance<input type="checkbox"/> Cold intolerance<input type="checkbox"/> Excessive sweating<input type="checkbox"/> Trouble sleeping<input type="checkbox"/> Trouble concentrating <p>Skin</p> <ul style="list-style-type: none"><input type="checkbox"/> Rashes<input type="checkbox"/> Sores<input type="checkbox"/> Easy bruising<input type="checkbox"/> Itching<input type="checkbox"/> Dryness<input type="checkbox"/> Color changes<input type="checkbox"/> Hair changes<input type="checkbox"/> Nail changes<input type="checkbox"/> Yellow skin or eyes <p>Eyes</p> <ul style="list-style-type: none"><input type="checkbox"/> Glasses or contacts<input type="checkbox"/> Vision loss<input type="checkbox"/> Eye pain<input type="checkbox"/> Eye redness<input type="checkbox"/> Blurred vision<input type="checkbox"/> Double vision<input type="checkbox"/> Flashing lights<input type="checkbox"/> Glaucoma<input type="checkbox"/> Cataracts <p>Ears</p> <ul style="list-style-type: none"><input type="checkbox"/> Decreased hearing<input type="checkbox"/> Ringing in ears<input type="checkbox"/> Earache<input type="checkbox"/> Ear drainage <p>Nose</p> <ul style="list-style-type: none"><input type="checkbox"/> Stuffiness<input type="checkbox"/> Discharge<input type="checkbox"/> Hay fever<input type="checkbox"/> Sinus pain	<p>Mouth and Throat</p> <ul style="list-style-type: none"><input type="checkbox"/> Full dentures<input type="checkbox"/> Partial dentures<input type="checkbox"/> Bleeding gums<input type="checkbox"/> Sore tongue<input type="checkbox"/> Dry mouth<input type="checkbox"/> Sore throat<input type="checkbox"/> Hoarseness<input type="checkbox"/> Thrush<input type="checkbox"/> Non-healing sores<input type="checkbox"/> Last dental visit date: <p>Neck</p> <ul style="list-style-type: none"><input type="checkbox"/> Enlarged thyroid (goiter)<input type="checkbox"/> Lumps<input type="checkbox"/> Swollen lymph nodes <p>Breasts</p> <ul style="list-style-type: none"><input type="checkbox"/> Lumps<input type="checkbox"/> Pain<input type="checkbox"/> Discharge<input type="checkbox"/> Breastfeeding currently<input type="checkbox"/> Last mammogram date: <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Cough<input type="checkbox"/> Sputum<input type="checkbox"/> Coughing up blood<input type="checkbox"/> Shortness of breath<input type="checkbox"/> Wheezing<input type="checkbox"/> Painful breathing <p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> High blood pressure<input type="checkbox"/> Chest pain, discomfort or tightness<input type="checkbox"/> Palpitations (heart racing or skipping)<input type="checkbox"/> Shortness of breath with activity<input type="checkbox"/> Difficulty breathing lying down<input type="checkbox"/> Sudden awakening from sleep short of breath<input type="checkbox"/> Swelling in legs or feet<input type="checkbox"/> Calf pain with walking	<p>Gastrointestinal</p> <ul style="list-style-type: none"><input type="checkbox"/> Swallowing trouble<input type="checkbox"/> Heartburn<input type="checkbox"/> Nausea<input type="checkbox"/> Vomiting<input type="checkbox"/> Abdominal pain<input type="checkbox"/> Change in bowel habits<input type="checkbox"/> Constipation<input type="checkbox"/> Diarrhea<input type="checkbox"/> Rectal bleeding<input type="checkbox"/> Black stools<input type="checkbox"/> Last colonoscopy date: <p>Urinary</p> <ul style="list-style-type: none"><input type="checkbox"/> Frequent urination<input type="checkbox"/> Urgency<input type="checkbox"/> Burning or pain<input type="checkbox"/> Blood in urine<input type="checkbox"/> Decreased urine flow<input type="checkbox"/> Incontinence (leaking)<input type="checkbox"/> Kidney stones (ever) <p>Reproductive Health</p> <ul style="list-style-type: none"><input type="checkbox"/> Menstrual irregularities<input type="checkbox"/> Menopause symptoms<input type="checkbox"/> Sexual problems <p>Musculoskeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Muscle pain<input type="checkbox"/> Muscle cramps<input type="checkbox"/> Joint pain<input type="checkbox"/> Joint swelling<input type="checkbox"/> Neck pain<input type="checkbox"/> Back pain <p>Neurologic</p> <ul style="list-style-type: none"><input type="checkbox"/> Headaches<input type="checkbox"/> Dizziness<input type="checkbox"/> Muscle weakness<input type="checkbox"/> Numbness<input type="checkbox"/> Tingling<input type="checkbox"/> Tremor <p>Mental Health</p> <ul style="list-style-type: none"><input type="checkbox"/> Nervousness or anxiety<input type="checkbox"/> Stress<input type="checkbox"/> Depression
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Family History

Please list health problems in your family, such as:

- ✓ Diabetes (include “type 1” or “type 2” and age of diagnosis if known)
- ✓ High cholesterol
- ✓ High blood pressure
- ✓ Heart disease
- ✓ Stroke
- ✓ Thyroid problems
- ✓ Cancer (include type if known)
- ✓ Depression

Include cause of (and age at) death if known.

Year of Birth Healthy Died Health problems:

	Year of Birth	Healthy	Died	Health problems:
Father		<input type="checkbox"/>	<input type="checkbox"/>	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 1		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 2		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 3		<input type="checkbox"/>	<input type="checkbox"/>	
Brother 4		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 1		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 2		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 3		<input type="checkbox"/>	<input type="checkbox"/>	
Sister 4		<input type="checkbox"/>	<input type="checkbox"/>	
Son 1		<input type="checkbox"/>	<input type="checkbox"/>	
Son 2		<input type="checkbox"/>	<input type="checkbox"/>	
Son 3		<input type="checkbox"/>	<input type="checkbox"/>	
Son 4		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 1		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 2		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 3		<input type="checkbox"/>	<input type="checkbox"/>	
Daughter 4		<input type="checkbox"/>	<input type="checkbox"/>	

My Concerns

Please circle one response to each statement using this scale:

- 1 - Strongly agree
- 2 - Somewhat agree
- 3 - Not sure
- 4 - Somewhat disagree
- 5 - Strongly disagree

I am satisfied with my present level of understanding of diabetes:	1	2	3	4	5
I understand the importance of good blood sugar control:	1	2	3	4	5
I can accurately measure and record my own blood sugar:	1	2	3	4	5
I know what to do with the results of my blood sugar tests:	1	2	3	4	5
I am careful with my meal plan:	1	2	3	4	5
I exercise on a regular basis:	1	2	3	4	5
I am satisfied with my present weight:	1	2	3	4	5
If on insulin, I know how to adjust my insulin:	1	2	3	4	5
I know what to do when my blood sugar is too high:	1	2	3	4	5
I know what to do when my blood sugar is too low:	1	2	3	4	5
I think stress affects my diabetes:	1	2	3	4	5
I worry a lot about my diabetes:	1	2	3	4	5
I wish I was better motivated to take care of myself:	1	2	3	4	5
My family is concerned about my diabetes:	1	2	3	4	5
I want to be an active participant in my diabetes care:	1	2	3	4	5

What's the hardest thing about having diabetes and having to manage it every day? _____

What do you think are your greatest diabetes care problems? _____

What do you think are your greatest strengths? _____

Other comments you would like to make to help us meet your needs? _____

Thank you. Please be sure to return completed form promptly.

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