Demographics

Name: _____ Date: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Place of work (if employed): _____ Work Phone: _____

Notify in Emergency: _____ * number you prefer to be contacted

ALLERGIES: _____ Date of Birth: _____

Gender: ☑ Female Race: _____ Height_____ Current Weight_____ Prepregnancy Wt._____

Do you have a family history of diabetes? Yes_____ No_____ Who?_____

Do you follow a meal plan ? ❒ Yes ❒ No

What type of meal plan do you follow (include any restrictions)? _____

❒ Sugar ❒ Salt ❒ Fat ❒ Protein ❒ Other

What times do you eat your meals and snacks? _____

Do you eat at the same time each day? ❒ Yes ❒ No

Who prepares your meals? _____

How many meals per week do you eat away from home? ❒ 0–1 ❒ 2–4 ❒ 5–8 ❒ more than 9

Medication: Please list all the medications you take with time, amount, and the reason you take it (***include over the counter and herbal medications***):

Medication Name	Time Taken	Amount Taken	Reason

Any Side Effects from any of your meds ? ☐Yes ☐No If yes, which ones and what?_____

_____ Have you discussed this with your MD? ☐Yes ☐No

Do you exercise? ❒ Yes ❒ No How often? _____Type of exercise?_____

How long?_____ Time of day? _____

Do you already check your blood glucose at home? ❒ Yes ❒ No

What meter do you use? _____ How often? _____

Do you adjust your own medication based on your blood glucose? ❒ Yes ❒ No

Do you keep a record of your blood glucose? ❒ Yes ❒ No

How many days a week is your blood glucose over 90 before eating? _____

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Medical History

Do you currently have or have you ever had:	Yes	No	Don't Know	Do you currently have or have you ever had:	Yes	No	Don't Know
Cardiac Problems (Heart)				Frequent Infections			
High Blood Pressure				Kidney Problems			

For Gestational Diabetes: Due Date_____
How many times have you been pregnant?_____ How many living children?_____ Have you ever been told you had gestational diabetes in the past?**Y___ N____ If yes, how many times and when?**_____

Alcohol Use? ❒ Yes ❒ No Amount? _____ How often? _____
Tobacco Use? ❒ Yes ❒ No Amount? _____ How often? _____
Cigarettes❒ Cigar❒ Pipe❒ Snuff❒ Chewing❒
Would you like information on Tobacco cessation? ❒ Yes ❒ No Information provided_____(Init.)

Do you have family and friends that you can turn to when you need help/support? ❒ Yes ❒ No
Stress level: ❒ Low❒ Medium❒ High How does stress change your blood sugar?_____

Schedule / Training Needs

Do you work outside of the home? ❒ Yes ❒ No
What hours do you usually work?_____What type of work do you do? _____
How many years of school have you completed? _____
If you have had gestational diabetes before, did you attend classes for training? Y_____ N _____
If yes, where and when?_____

Are there any language, religious, or cultural factors that we need to consider in teaching you to manage your diabetes? ❒ Yes ❒ No If Yes, Describe: _____
Do you have any problems that we should know about that might interfere with your ability to learn about diabetes in a classroom setting (visual, hearing, reading, language)? ❒ Yes ❒ No If Yes, Specify:
_____
Do you have any financial/resource concerns that may affect your ability to care for your diabetes?
❒ Yes ❒ No If yes, select any that apply:
❒ Food ❒ Medication ❒ Strips ❒ Heating ❒ Transportation ❒ Other _____
Community Resource Sheet provided._____(Init.)

How do your learn best? ___Reading ___Demonstration ___Discussion ___Other
What are you most interested in learning about related to your diabetes? _____
_____

What can you do to better take care of your diabetes? _____
How ready do you feel to make healthy changes at this time?
❒ 1 – Not ready ❒ 2 – May be ready ❒ 3 – Somewhat ready ❒ 4- Ready ❒ 5 – Very ready

Have you ever used services at this hospital before? ❒Yes ❒ No

Reviewed By: _____ Date: _____

Reviewed By: _____ Date: _____

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