Diabetes Management Pediatric Assessment

Name:			Today's Date:	
Address:			Date of birth:	
City:	State:	Zip:	Home Phone:	
Primary Care Givers: Names/Relationships:				
Parent's Work Location:			Parent's Work Phone:	
Email: (optional)			Parent's Cell phone:	

Gender: ☐ Female ☐ Male Race:_____ Current Weight : _____pounds Height:_____

Allergies to Food or Medications: ☐ None **OR** _____

How long have you had diabetes? ☐ New diagnosis ☐ _____months ☐ _____years

What type of diabetes do you have? ☐ Type 1 diabetes ☐ Type 2 diabetes ☐ Not sure

On a scale of 1-3, please rate your child's overall health? ☐ 1 – Poor ☐ 2 – Good ☐ 3 – Very Good

How often do you go to the doctor for diabetes? _____ time(s) a year ☐ Newly diagnosed/don't know

$HgbA1_C$ Date	Result _____%		☐ Do not know	☐ Not done
How often do you go to the eye MD?	_____ time(s) every year		☐ Do not go	☐ Infrequently
Vision problems?	☐ Yes		☐ No	☐ Do not know
Dilated eye exam? Date	☐ Normal	☐ Retinopathy	☐ Not done	☐ Do not know
Heart problems/ Heart Surgery?	☐ Yes	Yr_____	☐ No	☐ Do not know
Lipid test Date	_____ Cholesterol	_____ HDL _____ LDL	_____ Triglycerides	☐ Not done ☐ Do not know
High blood pressure?	☐ Yes		☐ No	☐ Do not know
Kidney problems?	☐ Yes		☐ No	☐ Do not know
Serum creatinine Date	Result _____		☐ Not done	☐ Do not know
Urine for protein Date	☐ Negative	☐ Positive	☐ Not done	☐ Do not know
Frequent infections?	☐ Yes Type:_____		☐ No	☐ Do not know
Foot exam by MD Date	☐ Foot problems present		☐ No problems	☐ Not done
Pain/numbness/burning in feet or legs?	☐ Yes		☐ No	
Do you practice daily foot care?	☐ Yes		☐ No	
How often do you go to the dentist?	_____ time(s) every yr		☐ Do not go	☐ Infrequently
Dental problems?	☐ Yes _____		☐ No	

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Please list any other health issues/concerns:_____

_____

Has your child had a flu shot within the last 12 months? ☐Yes ☐No

Does your youth smoke/use tobacco? (if yes, amount:_____) ☐Yes ☐No

Does your youth drink alcohol? (amount/frequency:_____) ☐Yes ☐No

Does your child have preferred play or sports activities? ☐Yes ☐No

Does your child participate in any team sports or classes/dance? ☐Yes ☐No

How many times a week? _____ Time of day?_____

Tires easily? ☐ Yes ☐No Requires any special equipment, if so what?_____

Any history of developmental delay? ☐Yes ☐No Explain_____

_____

Infants/early childhood: ☐N/A Sleeps in: ☐ bed ☐ crib

☐rolls over ☐crawls ☐walks ☐runs ☐bike/trike

Speech: ☐ Coo/babble ☐1-2 words ☐Sentences

Any difficulty:

☐ Seeing ☐ Hearing ☐ Learning

Is your teen allowed to date? ☐Yes ☐No

Drive? ☐Yes ☐No ☐ N/A

Has your child spent the night away from home since diagnosis? ☐Yes ☐No

When/With Whom? _____

Do you manage your diabetes differently when you are sick? ☐Yes ☐No

Does your child follow a meal plan for your diabetes? ☐Yes ☐No

Do you count carbohydrates? ☐ Yes ☐ No Who is responsible? ☐ Child ☐ Parent

Within the last year, how many times have you:

Been in the emergency room? _____ time(s) For diabetes: ☐Yes ☐No

Been a patient in the hospital? _____ time(s) For diabetes: ☐Yes ☐No

Diabetes Medication: Check the type of diabetes med(s) you are taking and list dose and when taken:

Injectable diabetes medication(s) you are currently taking:

☐ Humalog (lispro) ☐ NovoLog (aspart) ☐ Apidra (glulisine) **Humulin/Novolin** ☐ **R** (Regular) **Dose(s) and when**: _____ _____ Doses at school? Y or N	**Humulin/Novolin** ☐ **N** (NPH) ☐70/30 ☐50/50 **Dose(s) and when**: _____ _____ _____	**Humalog/Novolog Mix** ☐ 70/30 ☐ 50/50 ☐ 75/25 **Dose(s) & When:** _____ _____ _____	☐ Byetta (exenatide) ☐ Victoza (liraglitide) ☐ Symlin (pramlinitide acetate) **Dose(s) and when**: _____ _____

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☐ Lantus (glargine) ☐ Levemir (detemir) **Dose(s) and When**:_____

Who is responsible for drawing up/preparing and giving injections? ☐ Child ☐ Parent

Do you use an insulin pump? ☐ Yes/ Type_____ Basal Rates_____
☐ No _____

Have you ever worn a pump? If yes, why did you stop?_____

Biguanide	**DPP-4 Inhibitor**	**Sulfonylurea**	**Combinations:**
Metformin ☐ Glucophage ☐ Glucophage XR/ Glumetza (metformin extended release) **Dose:** _____ **When taken:** _____	☐ Januvia ☐ Onglyza **Dose:** **Taken: AM / PM**	☐ DiaBeta (glyburide) ☐ Micronase (glyburide) ☐ Glynase (glyburide) ☐ Glucotrol (glipizide) ☐ Glucotrol XL (glipizide) ☐ Amaryl (glimepiride) **Dose:** _____ **When taken:** _____	☐ Glucovance (glyburide & metformin) ☐ Janumet™ (sitagliptin and metformin) ☐ Metaglip (glipizide & metformin) **Dose:** _____ **When taken:** _____

Other Medications: Please list all the non diabetes medications you take along with the dose, time and reason for taking the medication (Use back of form **OR attach a list for additional medications**): *

Name of medication	Dose	Time Taken: (Daily, Mealtime, PM, Bedtime)	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 take **over-the counter** meds or **herbals/supplements/vitamins**? ☐ Yes * ☐ No

*Attach list or use back of form

Low blood glucose/sugar (**hypoglycemia**):

Has your blood glucose ever dropped too low? ☐ Yes ☐ No ☐ Do not know

How would you feel or how do you know when you have low blood glucose? ☐ Do not know

_____

Do you have a glucagon emergency kit? ☐ Yes ☐ No ☐ Do not know

What do you have with you to treat low blood glucose today?

_____ ☐ Nothing

Do you wear diabetes identification? ☐ Yes ☐ No

7. Blood glucose **monitoring**: ☐ Have meter Type_____ ☐ Do not have meter

How often do you check your blood glucose? _____times every ☐ Do not check
☐ day ☐ week ☐ month

What is an acceptable blood glucose range? _____ ☐ Do not know

_____

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Do you have problems getting testing supplies? ☐ Yes ☐ No

Do you keep a written log or download meter routinely? ☐ Yes ☐ No

Who is responsible for monitoring? ☐ Child ☐ Parent

For **Teen Girls**: Are you using some type of birth control? ☐ Yes What?_____ ☐ No

Are you pregnant? ☐ Yes ☐ No Have you ever had gestational diabetes? ☐ Yes ☐ No

Are you planning to become pregnant? ☐ Yes ☐ No

Stress and Support Systems: On a scale of 1 – 5, how would you rate your stress level?

☐ 1- Very low stress ☐ 2- Low stress ☐ 3- Moderate stress ☐ 4-High stress ☐ 5- Very high stress

Have you attended Diabetes Camp? ☐ Yes ☐ No If yes, when and where?_____

Participated in kid's support group activities? ☐ Yes ☐ No

Schedule and Learning Needs: If a Student, what grade?_____ ☐ Home ☐ Public/Private

Is your youth employed? ☐ Yes ☐ No How many hours per week? _____

Type of work ?_____ Usual hours: ☐ Days ☐ Evenings ☐ Nights

List any language, religious, cultural, financial factors that we need to consider in working with you on your diabetes management plan: _____ ☐ None

How does your child learn best? ☐ Reading ☐ Demonstration ☐ Discussion ☐ Other_____

How ready are you & your child to make changes in managing diabetes?

☐ 1- Not ready ☐ 2- May be ready ☐ 3- Somewhat ready ☐ 4- Ready ☐ 5- Very ready

What are you/your child most interested in learning about your diabetes? (check boxes below)

☐ General info ☐ Physical activity ☐ Acute complications (low blood sugar/illness, etc.)

☐ Medications ☐ Blood glucose monitoring ☐ Chronic complications (cardiac, kidney, eyes, feet, etc)

☐ Meal planning ☐ Preconception care ☐ CHO counting:

☐ Insulin adjustment ☐ Other: _____

What do you want to accomplish by attending this program? _____

_____

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

_____ _____

Instructor Signature /Credentials Date

_____ _____

Instructor Signature/Credentials Date

_____ _____

Instructor Signature/Credentials Date

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