The Diabetes Learning Center
Elmhurst Memorial Healthcare
Center for Health 1200 S. York St., Elmhurst, IL
Diabetes Assessment

Name_____ Age_____ Sex_____ Phone(H)_____Date:_____

Marital Status: M S W D Date of Birth:_____ Referring Physician_____

Do you work? (doing what/where)_____

When were you first told you had diabetes? (month/year)_____

Allergies_____

Do you have any of the following diseases or conditions: (please check):

_____High blood pressure	_____Breathing Problems	_____Hearing
_____Stroke	_____Digestion Problems	_____Vision
_____High Cholesterol	_____Erectile Dysfunction	_____Thyroid
_____Heart Problems	_____Arthritis/Motor Problems	

Past Surgeries_____

Other_____

Have you been to the ER or admitted to the hospital in the past year? Yes_____No_____#Times_____

For what reason(s): _____

Please list all medication taken at home:

Medication	Dose	Frequency

For Revisit Use Only: Changes to Previous Home Medications:

Date	New or Changed Medication	Dose	Frequency

HEALTH HISTORY/RISK FACTORS

- Have you ever attended any diabetes education classes? Yes _____ No _____
  When _____ Where _____
- Do any of your relatives have diabetes? Yes _____ No _____ Who: _____
- Have you had a glycohemoglobin (A1C) test? When _____ Result _____

- Are you testing your blood sugars at home? Yes _____ No _____
  If yes: How many times each day? _____ Name of meter: _____
- What are your blood sugar ranges?

  Before Breakfast _____ Bedtime _____
  Before Dinner _____ Other _____
- Do you have low blood sugar reactions? Yes ____ No ____ If yes, how many times per month?_____
- When do they occur? Morning_____ Afternoon_____ Evening_____ Overnight_____
- How do you feel? Shaky_____ Sweaty_____ Hungry_____ Other_____
- How do you treat your low blood sugars? Glucose tabs_____ Gel_____ Other_____

- Do you wear some form of medical ID? Yes _____ No _____
- Do you smoke? Amount per day _____ For how may years _____
  Have you ever smoked? Yes _____ No _____ How long ago did you quit? _____
- When was your last dilated eye exam? _____
  Have you ever had eye or vision problems? (Retinopathy) Explain _____
  Treatment (if needed) _____
- When was your last dental exam? _____
- Have you ever had any kidney problems? Explain _____
  Treatment (if needed) _____
- Have you ever had any numbness, pain or burning in hands and/or feet? Explain _____
  Treatment (if needed) _____
- Have you ever had any toenail or foot problems, cuts, or sores that don't heal? Explain
  _____

- Do you exercise regularly? Type _____ # Minutes _____ Frequency _____
  If no, what prevents you from exercising? _____
- Do you get enough rest at night? _____
- Do you feel pain anywhere? _____
- **Women:** Do you plan on future pregnancies? Yes _____ No _____

CURRENT DAILY SCHEDULE

A Typical Day Write in times for all that apply	When do you exercise? Check any that apply	When do you take your Diabetes Medications? Check any that apply
_____I get up _____1st meal _____Snack _____2nd meal _____Snack _____3rd meal _____Snack _____Bedtime _____Time I start work _____Time I am home from work	Before breakfast_____ After breakfast_____ Before lunch_____ After lunch_____ Before dinner_____ After dinner_____	Before meals_____ During meals_____ After meals_____

NUTRITION HISTORY

- Your height_____ Your weight_____
- Has your weight changed in the past six months? lbs gained _____ lbs lost _____ Why?_____
- Have you ever had any diet instruction for diabetes? Yes _____ No _____
  If yes, when _____ By whom _____
  What was taught? _____
  Were you able to follow the plan? Yes____ No____ If no, why _____
- Is there anything wrong with the way you eat? Yes____ No____
  If yes, what's wrong _____
  Will it be difficult to make healthy food choices? Yes____ No____ Why _____
- Do you follow any special diet?
  Low calorie ____ Low fat ____ High fiber ____ Other (specify) _____
  Low salt ____ Low protein ____ Vegetarian ____
- Do you get up during the night to eat?
- Who does most of the shopping/cooking? You____Spouse____Friend_____Other___
- Do you take any nutrition supplements?(vitamins/mineral/herbs)?
  _____
- Do you drink any alcohol? Beer _____ How often _____ Amount _____
  Wine _____ How often _____ Amount _____
  Other _____ How often _____ Amount _____
- Do you eat any meals away from home?(such as fast food, carry out, delivery, brown bag, cafeteria, buffet, sit down restaurant) How Often: Breakfast _____x weekly Where: Breakfast _____x weekly
  Lunch _____x weekly Lunch _____x weekly
  Dinner _____x weekly Dinner _____x weekly
- How many times in one week do you eat the following food?
  Regular pop or sugary drinks _____ Candy bars/pieces _____ Pies/cakes _____
  Fruit juice _____ Ice cream, puddings _____ Sweet rolls/pasteries _____
  Hard Candy _____ Cookies _____ Other sweets _____

LEARNING NEEDS

- Do (or will) any of the following make your diabetes management difficult?
  Culture _____ Language _____ Hearing _____
  Religion _____ Reading Ability _____ Vision _____

- What changes in your lifestyle would you most like to make?
  Improved eating habits _____ Test blood sugar more often _____ Avoid low blood sugar reactions ____
  Increased exercise _____ Lose weight _____ I don't want to make any changes ___
  Reduce stress _____ Lower cholesterol _____

How do you feel about having diabetes? _____

FOR EDUCATORS USE ONLY

Lab Values:

_____

_____

NOTES:_____