Diabetes Learning Center
Elmhurst Memorial Healthcare
Elmhurst, IL 331-221-6440

Hypoglycemia Assessment

Name____________________________ Phone ___________________ Date:____________

Date of Birth _____________________ Sex _______

Marital Status: M S W D Referring Physician_________________________________

Do you work? (doing what/where)____

Allergies____

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

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

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

CURRENT DAILY SCHEDULE

A Typical Day Write in times for all that apply	When do you exercise? 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__________

NUTRITION HISTORY

- Your height_________ Your weight___________
- Has your weight changed in the past six months? lbs gained _____ lbs lost _____ 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 ______

HEALTH HISTORY / RISK FACTORS

- What are your Hypoglycemia symptoms:
  Shaky _____ Sweaty _____ Hungry _____ Other ____
  When do they occur: Morning _____ Afternoon _____ Evening _____ Overnight _____
  How do you treat your symptoms: ____

- 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 dental exam? _________________

LEARNING NEEDS

- 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 _____

FOR EDUCATORS USE ONLY

Lab Values:
____
____

NOTES:____
____
____
____
____
____
____
____
____
____
____
____
____
____
____