Elmhurst Memorial
Center for Health
William and Carol Parrillo Building

Provider Referral Form
Diabetes Learning Center

Phone: (331)221-6440 Fax: (331)221-3736

Pre-Diabetes Assessment

Name____________________________ Date of Birth_________ Sex ____ Date_______

Marital Status: Married Single Widowed Divorced Physician___________________

When were you first diagnosed with pre-diabetes?____________Do you smoke? Yes No

Do you work? Yes No What type of work do you do?____________________________

What type and how much exercise do you get? ___________________________________

List the names of all medicines and nutrition supplements you take:_________________

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Do you have any of the following risk factors for diabetes?

	YES	NO		YES	NO
Overweight	___	___	Diabetes of pregnancy	___	___
Physically inactive	___	___	Baby over 9 pounds at birth	___	___
High blood pressure	___	___	Stroke	___	___
High cholesterol	___	___	Heart attack	___	___
Family member with diabetes	___	___	Erectile dysfunction	___	___
Blood vessel problems of heart, brain, legs	___	___			

What is your racial background?
___ African-American
___ Hispanic-Latino
___ Asian
___ American Indian
___ Caucasian

Describe what you eat on a typical day:

Diabetes Educator—Enter value and date:

HbgA1c:_______ FBS:________ LDL:_______ ____________
Height:_________ Chol:________ VLDL:______ ____________
Weight:________ HDL:________ TRIG:_______ ____________ 11/11 cla