ADULT DIABETES HISTORY

Name:	Phone:
	E-mail:
Date Of Birth:	Cell:
Primary/Referring Physician:	Phone:

When were you diagnosed with diabetes?

Marital Status:
☐Single ☐Married ☐Divorced ☐Widowe ☐Separated ☐Cohabitating

# in household	Relationship	Will significant others participate in program? ☐No ☐Yes- relationships: Names:

Race (check all that apply)
☐ White ☐Black or African American ☐ American Indian or Alaska Native
☐ Asian ☐Native Hawaiian or Pacific Islander ☐ Spanish, Latino, or Hispanic

What level of schooling have you completed?
☐Elementary School ☐High School Diploma ☐Some College ☐College/University
☐ Technical/Vocational/Business ☐Military Training ☐Graduate School ☐Other:

Have you ever had diabetes education?
☐No ☐Yes Where? Date:

Do you have specific diabetes questions or goals for your education visits?
☐No ☐Yes What are they?

Do you have any medication allergies?
☐No ☐Yes Explain:

Have you ever been diagnosed with any of the following conditions, or do you have a concern?

Diagnosed	Concerned		Diagnosed	Concerned	
☐	☐	High blood pressure	☐	☐	Eye or vision problems
☐	☐	Heart Disease	☐	☐	Kidney disease
☐	☐	Abnormal blood lipids	☐	☐	Skin Problems
☐	☐	Circulation problems	☐	☐	Dental or mouth problems
☐	☐	Numbness/Pain (hands/legs/feet)	☐	☐	Liver disease
☐	☐	Foot Problems	☐	☐	Stomach or bowel problems
☐	☐	Thyroid Disease	☐	☐	Depression

Family History of:

☐ No ☐ Yes Diabetes
☐ No ☐ Yes Thyroid disease
☐ No ☐ Yes Heart disease

List surgeries and/or hospitalizations with dates:

Type of Surgery/Reason for Hospitalization:________________________________ Date:__________
Type of Surgery/Reason for Hospitalization:________________________________ Date:__________
Type of Surgery/Reason for Hospitalization:________________________________ Date:__________
Type of Surgery/Reason for Hospitalization:________________________________ Date:

Date of last eye exam	Date of last dental exam	Date of last foot exam

If you are female:
Are you pregnant? ☐ No ☐ Yes
Are you considering pregnancy? ☐ No ☐ Yes
Are you currently using birth control? ☐ N/A ☐ No ☐ Yes
Type of birth control:________________________________
Are your menstrual cycles regular? ☐ N/A ☐ No ☐ Yes
If no, Explain:

NUTRITION AND LIFESTYLE HISTORY

What food planning methods have you follow in the past? (check all that apply)

☐ Calorie counting ☐Exchange lists ☐ Food pyramid/Healthy choices ☐ No specific plan
☐ Carb counting ☐Fat gram counting ☐ No added sugar ☐ Low carbohydrate

Do you already have a prescribed meal plan or special diet from your doctor or dietitian?

How often do you follow a diabetes food plan?

☐Never/Rarely ☐Occasionally/sometimes ☐Most of the time ☐ All of the time

Typical Day Schedule and Meals:

Please fill in the **times** of your meals and snacks, along with an example of the **type** and **amount** of food you might eat for your meals and snacks.

	Time:	USUAL MEALS-Example of food & beverages in a typical day
I get up at		
Breakfast		Breakfast:
Morning snack		Morning Snack:
Lunch		Lunch/midday meal:
Afternoon snack		Afternoon snack:
Dinner		Dinner/Evening Meal:
Evening/Bedtime snack		Evening/Bedtime snack:
I go to bed at		

Do you exercise?

☐No ☐Yes What type(s)?
☐Walking ☐Biking ☐Weights ☐Sports ☐ Swimming ☐ Aerobic machine ☐Yoga

How many times per week do you exercise? **For how many minutes per time?**

Have you ever been advised by a physician to limit your exercise in any way?

☐ No ☐ Yes Explain:

Is your job active or inactive? ☐ Active ☐ Inactive

Explain:

Has your weight changed in the past year?

☐ No ☐ Yes How much? ☐ Gain ☐Loss

Do you use alcohol?

☐ No ☐ Yes Type(s) amount, and times per week:

Do you use tobacco?

☐ No ☐ Yes Type: Amount per day:

Former tobacco user?

☐ No ☐ Yes Quit date?

Do you use street drugs?

☐ No ☐ Yes

List all of your medications including over-the-counter medications & Vitamin/Mineral Supplements & Herbs
(Use separate paper if necessary)

Oral Diabetes Medications

Start Date	Name	Dose	Time of Day	Side Effects?
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

Please describe any Side Effects

INSULIN

If you use insulin, please circle the types of insulin you are taking and your present insulin doses.

	Breakfast	**Lunch**	**Dinner**	**Bedtime**	**Snacks**
Regular Humalog (Lispro) Novolog (Aspart)					
NPH Lantus					
70/30 (with Aspart) 70/30 (with Regular) 75/25 (with Lispro) 50/50 (with Regular)					

Insulin Pump Users: Please answer the following:

Time	**Morning**	**Afternoon**	**Evening**
Carbs			
Bolus			
Basal			

If you take insulin, please answer the following:

Are you using insulin-to-carbohydrate ratio?
☐ No ☐ Yes What is the ratio? ______Units of insulin per ________ grams of carbohydrates

Do you supplement with extra insulin when your blood glucose is high (sliding scale)
☐ No ☐ Yes Fill in the scale you use in the table:

Injection sites
☐Stomach ☐Arm ☐Leg ☐Buttocks

Where do you store unopened insulin?

Do you use an insulin pen?
☐ No ☐ Yes Name:

Where do you dispose of needles/syringes/lancets?

Supplemental Scale (correction factor)	
Blood Glucose	**Plus Insulin**

BLOOD GLUCOSE MONITORING:

Are you testing your blood glucose (sugar)?
☐ No ☐ Yes How Often?___________

What type of meter do you use?

What time(s) of the day do you test?

Do you have a target blood glucose range?
☐ No ☐ Yes
What is it? ________mg/dl to ________mg/dl

Do you know your last A1C?
☐ No ☐ Yes Result: Date:

Do you have a target A1C?
☐ No ☐ Yes What is it?

Do you ever check your ketones?
☐ No ☐ Yes When?

Do you use foil-wrapped ketone strips?
☐ No ☐ Yes

HYPOGLYCEMIA:

Do you experience low blood glucose (hypoglycemia)? ☐ No ☐ Yes
What time of day does it occur? Do you require assistance? ☐ No ☐ Yes

Do you have lows that you don’t feel?
☐ No ☐ Yes

Do you carry food or other source to treat lows?
☐ No ☐ Yes What?

Do you wear a medical ID?
☐ No ☐ Yes

Do you have a glucagon emergency kit?
☐ No ☐ Yes Expiration date:

LIFESTYLE AND BEHAVIORAL ASSESSMENT

My Diabetes:

What are your most important concerns in managing diabetes?

What would you most like to learn during your visits for diabetes education?

Check the health concerns below that affect you:

- ☐ Difficulty sleeping (such as insomnia, sleep apnea, nightmares, talking your sleep)
- ☐ Problems with eating or exercising (such as eating too little, avoiding food, overeating, over-exercising)
- ☐ Depression or noticeable mood changes (such as feeling sad, having mood swings, irritability)
- ☐ Anxiety, nervousness, or stress (such as feeling worried all the time, tense)
- ☐ Difficulty in social, school or work environments (such as decreased productivity, avoidance, social isolation, withdrawal)
- ☐ Difficulty with relationships with other people (such as friends, people at work)
- ☐ Problems within your family (such as conflict, marital conflict, disciplining children)
- ☐ Problems with certain kinds of inappropriate or undesirable behavior (such as aggression, anger repeating behaviors you do not want to repeat, illegal behavior)
- ☐ Addictive behaviors (such as drug or alcohol abuse, gambling, workaholic behavior)
- ☐ Problems with sexual functioning (impotence, loss of desire, avoidance, orgasmic problems)

Other Concerns Specific to Diabetes

- ☐ Difficulty coping with diabetes (e.g. not being able to test your blood glucose or eat when you need to)
- ☐ Problems within your family (e.g. difficulty setting limits with family members or getting support)
- ☐ Challenges at work (e.g. getting time to take care of diabetes, discrimination due to diabetes)
- ☐ Problems in social situations or relationships due to diabetes (e.g. testing or eating in front of others)
- ☐ Have you ever been involved in therapy with a counselor or psychologist? ☐ No ☐ Yes

For what reason?

When?

With Whom?

What was helpful?

What was not helpful?

Who completed this form?	Relationship to Patient
Patient Signature	

FOR HEALTH PROFESSIONAL USE

- ☐ Referral made and accepted
- ☐ Referral made and refused
- ☐ Referral pending

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