Document Type: Forms/Other

MSC077

METHODIST PHYSICIANS CLINIC

DIABETES ASSESSMENT RECORD

Please complete this form and bring it with you to your appointment or class.

Name: _____D.O.B._____

Provider's name who is managing your diabetes: _____

Preferred contact phone number: _____

Does someone help you with your diabetes? ☐ No ☐ yes **I**f yes, who is that person:_____

Education and Work Status

Highest Level of Education: _____

Work status: ☐ Employed ☐ Not employed ☐ Retired ☐ Disabled ☐ Student

Type of job and work hours (if employed): _____

How many people (including yourself) live in your household? _____

Current Health History

Height: _____ Weight: _____

I would rate my current stress level (circle a number): (lowest) 1 2 3 4 5 (highest)

I reduce my stress by: _____

Non-Diabetes medications: ☐ Check this box if you brought your list of medications to the appointment

Medication	Amount in My Dose	Times Taken	Reason for Taking

Diabetes History

What year were you diagnosed?:_____ Type of diabetes: ☐ Type 2 ☐ Type 1 ☐ Not sure

Have you ever attended diabetes education class? ☐ No ☐ Yes If yes, where & when?_____

Do you examine your feet? ☐ No ☐ Yes If yes, how often? ☐ Daily ☐ weekly ☐ Monthly ☐ Occasionally

Did you have a diabetes eye exam in the last year? ☐ No ☐ Yes

Did you have a dental exam in the last year? ☐ No ☐ Yes

A1C test results: _____ Date: _____ Recent changes in A1C: _____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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☐ Check this box if you brought your list of medications to the appointment

Diabetes Medication	Amount in My Dose	Times Taken	Side Effects

How often do you test your blood sugars ? _____ Typical Readings: _____

☐ I do not test my blood sugars Name of my blood sugar meter: _____ ☐ Not sure

Do you have a continuous glucose monitor? ☐ No ☐ Yes If yes, what is it? _____

Do you have an insulin pump? ☐ No ☐ Yes If yes, what is it? _____

How often do you have a low blood sugar? ☐ Never ☐ Rare ☐ Occasional ☐ Frequent

What are your symptoms? _____ What is your blood sugar when feeling low?_____

How do you treat? _____

Have you ever experienced diabetic ketoacidosis? ☐ No ☐ Yes If yes, when?_____

Feelings about Diabetes

Circle one number: 1 = lowest 5 = highest

My knowledge of diabetes and its control is: 1 2 3 4 5

My confidence in actually being able to control my diabetes is: 1 2 3 4 5

My diabetes is a: ☐ Disaster ☐ Burden ☐ Problem ☐ Challenge ☐ Opportunity

I learn well from group discussion (check one box below):

☐ Strongly agree ☐ Agree ☐ Neither agree nor disagree ☐ Disagree ☐ Strongly disagree

Lifestyle Habits

Do you exercise? ☐ No ☐ Yes If yes, what type? _____

How many days per week? _____ How long each time? _____ OK'd by doctor? ☐ Yes ☐ No

Smoking History: ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker

Do you drink alcohol? ☐ No ☐ Yes If yes, number of drinks: ☐ per week or ☐ per day is =_____

Do you eat out? ☐ No ☐ Yes If yes, how often? _____ Where? _____

Do you skip meals? ☐ No ☐ Yes If yes, which meals? _____

Who does the cooking? _____ Who does the grocery shopping? _____

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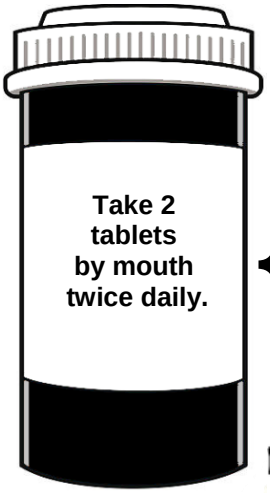
METHODIST PHYSICIANS CLINIC

What do you usually eat and drink? Please record time, food and amount

Breakfast			Lunch			Dinner		
Time	**Food**	**Amount**	**Time**	**Food**	**Amount**	**Time**	**Food**	**Amount**
(ex) 8 am	***Cereal***	***1 cup***						
Snack			**Snack**			**Snack**		
Time	**Food**	**Amount**	**Time**	**Food**	**Amount**	**Time**	**Food**	**Amount**

Please answer these questions:



Take 2 tablets by mouth twice daily.

According to the label to the left, how many pills would you take in 1 day?

_____

Nutrition Facts

2 servings per container

Serving size **1 cup (140g)**

Amount per serving

Calories **160**

	% Daily Value*
Total Fat 8g	**10%**
Saturated Fat 3g	**15%**
Trans Fat 0g	
Cholesterol 0mg	**0%**
Sodium 60mg	**3%**
Total Carbohydrate 21g	**8%**
Dietary Fiber 3g	**11%**
Total Sugars 15g	
Includes 5g Added Sugars	**10%**
Protein 3g	
Vitamin D 5mcg	**25%**
Calcium 20mg	**2%**
Iron 1mg	**6%**
Potassium 230mg	**4%**

*The % Daily Value tells you how much a nutrient in a serving of food contributes to a daily diet. 2000 calories a day is used for general nutrition advice.

Ingredients:
Whole wheat flour, corn bran, skim milk, whole eggs, salt, dried cherries, walnuts, coconut.

How many calories per serving?

_____

How much Total Carbohydrate in 2 servings?

_____

If you limit yourself to 10 g of Total Carbohydrate for your bedtime snack, how much of this food could you eat?

_____

If you were allergic to corn could you eat this food?

_____

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