Document Type: Forms/Other

MSC077

METHODIST PHYSICIANS CLINIC

PRE-DIABETES ASSESSMENT RECORD

I. PATIENT INFORMATION

Name: _____Age:_____ D.O.B._____Race:_____

Level of Education: _____Marital Status (circle): Single Married Widowed Divorced

Occupation: _____ Work Hours:_____

Provider's Name:_____

II. PRE-DIABETES HISTORY

How long have you had Pre-Diabetes?_____

What was your blood sugar when you were diagnosed?_____

Do you have a family history of diabetes? ☐ Yes ☐ No

III. GENERAL MEDICAL CONDITIONS?

Present health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently experiencing any pain? ☐ No ☐ Yes If yes, explain:_____

Date:_____

Total Cholesterol: _____ LDL: _____ HDL: _____ Triglycerides: _____

Allergies:_____

Medical conditions:_____

_____

List surgeries and/or hospitalizations in the past year: _____

Do you smoke? ☐ Yes ☐ No

IV. PHYSICAL ACTIVITIES/HABITS

Do you have a regular exercise program? ☐ No ☐ Yes

Type	Length of time	Intensity (circle)			# Times/Week
_____	_____	*Light*	*Medium*	*Heavy*	_____
_____	_____	*Light*	*Medium*	*Heavy*	_____

What, if any, physical limitations prevent you from exercising? _____

_____

V. GOALS

What do you hope to learn or gain from this education ? (i.e., workable exercise planning system, weight loss tips, …)

1._____

2._____

3._____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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VI. NUTRITION HISTORY

Weight:_____Height:_____ Weight changes in the last year? Increased Weight:_____ Decreased Weight:_____

1. Describe any prior weight loss experiences and/or programs you may have had:_____

   _____

2. Do you skip meals? ☐ No ☐ Yes If yes, which meals?_____ How often?_____
3. Do you do your own grocery shopping? ☐ Yes ☐ No
4. Who does the cooking at your house? ☐ Self ☐ Spouse ☐ Other:_____
5. Do you eat out? ☐ No ☐ Yes How often?_____ Where?_____
6. Do you drink alcohol? ☐ No ☐ Yes Type and amount:_____ How often?_____

In the space provided, record what you typically eat including type and amount of food.

Example:	*Cereal-Cheerios - 1 Cup* *Milk – Skim - 1 Cup* *Toast - 2 slices*
Meal Times	**Food Eaten and Amount**
Breakfast Time_____	
Snack Time_____	
Lunch Time_____	
Snack Time_____	
Dinner Time_____	
Snack Time_____	

Patient Label

NAME:_____DOB:_____

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