JENNIE EDMUNDSON HOSPITAL
An Affiliate of Methodist Health System

Diabetes Assessment Record

I. PATIENT INFORMATION

Name_____ Age_____ Race_____ Sex: ☐ Female ☐ Male Date _____
E-mail address:
_____
Marital status: ☐ S ☐ M ☐ W ☐ D Level of education_____ Occupation_____ Work hours
_____
Physician's name_____ Participant status: ☐ Inpatient ☐ Outpatient

II. GENERAL MEDICAL CONDITION

Lab test date: _____ A_1C_____ Total cholesterol_____ Triglycerides _____ HDL_____ LDL_____
Height_____ Current weight_____ Usual weight_____ Desired weight_____ Weight changes in past year: ↑ ↓_____
Allergies_____
_
Other medical problems_____
Present health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

III. DIABETES HISTORY

Type of diabetes: ☐ Type I ☐ Type II ☐ Medication-induced_____
Duration of diabetes _____
Treatment plan: ☐ Insulin ☐ Other injectables (Byetta, Symalin) ☐ Oral medications ☐ Diet & exercise alone
Name of insulin/injectable
_____
Units of insulin _____ at _____ times. Units of insulin _____ at _____ times.
Name of diabetes pill_____ Dosage _____ at these times _____ _____ _____ _____
Other medications_____
List concerns regarding your medications_____
Blood sugar monitoring: Test times
_____
Type of meter_____ Usual results: Fasting _____ After meals_____ Times_____

a. Do you ever have low blood sugar (hypoglycemia)? ☐ Yes ☐ No
b. What are your signs of low blood sugar? _____
c. How often does it occur and what time of day? _____
d. How do you treat a low blood sugar?
_____

Do you have a problem with?

☐ Feet_____ ☐ Vision_____ ☐ Wound healing_____
☐ Sensation_____ ☐ Kidneys _____ ☐ Heart _____

IV. DIETARY HABITS

Do you follow a special diet? ☐ Yes ☐ No Type of diet _____
Indicate times of: Breakfast_____ Lunch_____ Dinner_____ Snacks _____
Do you skip meals? ☐ Yes ☐ No If yes, how often? _____
Do you eat out often?: ☐ Yes ☐ No If yes, how often? _____ Where? _____
Do you do your own grocery shopping? ☐ Yes ☐ No If no, who does? _____
Who does the cooking at your house?
_____ Do you drink alcohol? ☐Yes ☐ No
If yes, type and amount. _____
Describe any weight loss experience or program you may have had?
_____
What topics about meal planning and food would be the most helpful?_____

V. PHYSICAL ACTIVITY HABITS

How would you rate your energy level? ☐ Low ☐ Low/Moderate ☐ Moderate ☐ Moderate/High ☐ High

Do you have a regular exercise program (20 minutes, 3 days a week)? ☐ Yes ☐ No If yes, indicate below.

Type	**Length of time**	**Intensity**	**Frequency**
_____	_____	☐ Light ☐ Medium ☐ Heavy	
_____	_____	☐ Light ☐ Medium ☐ Heavy	

Do you have any problems or conditions that restrict your activity (knee/hip/back pain, arthritis, retinopathy, recent surgery, etc.)? ☐ Yes ☐ No

Has your physician placed any restrictions on your activity (no lifting, etc.)? ☐ Yes ☐ No

VI. DIABETIC EDUCATION HISTORY

Prior diabetes education? Patient: ☐ Yes ☐ No Significant other(s): ☐ Yes ☐ No
When_____ Where _____
Will significant others participate in program? ☐ Yes ☐ No
Do you have problems reading? ☐ Yes ☐ No
Do you have problems hearing? ☐ Yes ☐ No
Other:
_____

VII. SOURCE OF REFERRAL

☐ Physician ☐ Self-referral ☐ Facility staff ☐ Community agent ☐ Other _____

VIII. PSYCHOSOCIAL HISTORY

Cigarettes per day_____ Alcoholic drinks per week_____ Type _____
Number of people living in your household_____ Relationship _____
How has diabetes affected your life? _____

Do you travel often? ☐ Yes ☐ No If yes, where and length of visits? _____

_____
_

_____
_

IX. GOALS

What do you hope to learn or gain from these classes/sessions? (Examples: Weight loss, meal plan/exchange system, workable exercise plan, blood glucose monitoring.)

a. _____
b. _____
c. _____
d.
_____

NS-re:Diabetes/Diabetes Class Assessment (for Webmaster 5-2011)

NUTRITION HISTORY

Name_____ **Age**_____ **Height**_____ **Weight**_____

Please complete the area below and indicate how you are currently eating. Record how you typically eat -- not what you think you should be eating. Be sure to include the exact type and amount of foods eaten. If your intake varies a lot between weekdays and weekends, give an example of each type of day.

Example: Mashed potatoes -- 1/2 cup and roast beef -- 2 oz.

	Day 1		Day 2	
Meal times	Food items (be specific)	Amount Eaten	Food items (be specific)	Amount Eaten
Breakfast time				
Snack time				
Lunch time				
Snack time				
Dinner time				
Snack time				