Diabetes Care Center | 318-224-3044 | Fax: 318-232-2978

COMPREHENSIVE DIABETES ASSESSMENT

TODAY'S DATE:

Patient name: ☐ male ☐ female Date of birth: Age:

Referring physician: Name of other person completing form:

Relationship: Why are you completing form?

SOCIO - ECONOMIC

Racial/ethnic group: ☐ white/Caucasian ☐ African American/black ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Hispanic ☐ Other:

Language spoken at home:

Transportation: ☐ car ☐ bicycle ☐ bus ☐ taxi ☐ train ☐ need ride from others ☐ other:

No. years school completed: Work status: ☐ employed ☐ not employed ☐ retired ☐ disabled ☐ student

Type of job and work hours:

Person(s) living with you:

Person(s) I'd like to bring to diabetes education program at no charge:

EDUCATIONAL NEEDS, LEARNING STYLE, BARRIERS, HEALTH GOALS and SUPPORT

I want to learn about these diabetes self-care topics: ☐ Eating healthy ☐ Being active (exercising) ☐ Coping well with having diabetes	☐ Reducing my risk of diabetes complications with my eyes, skin, feet, kidneys, nerves, heart and other body areas ***and*** reducing my risk of very high and low blood sugar	☐ Monitoring my sugar and indicators of health, such as blood pressure ☐ Solving diabetes problems that can and do occur ☐ Taking my medications	☐ Other:

Best ways I learn: ☐ discussion ☐ listening ☐ doing ☐ seeing ☐ touching ☐ reading ☐ videos/TV ☐ computer

Learning barriers: ☐ seeing ☐ hearing ☐ reading ☐ depression ☐ worry/fear ☐ attention deficit ☐ language ☐ memory ☐ lack of confidence ☐ can't sit long enough (too fidgety) ☐ other:

Support resources that may help me make self-care changes and reduce my barriers to these making changes:

☐ books/magazines ☐ videos/T.V. ☐ computer/emails/social networks ☐ live support groups ☐ doctor ☐ educator ☐ joining gym ☐ co-workers ☐ family ☐ friends ☐ caregiver ☐ financial:

Main support people in my life: ☐ spouse ☐ parent(s) ☐ child ☐ brother ☐ sister ☐ friend ☐ caregiver ☐ doctor ☐ other:

Health goals (clinical outcomes): *Improve my*: ☐ fasting blood glucose ☐ BG before lunch/dinner ☐ bedtime BG ☐ BG 2 hrs after meals ☐ A1C ☐ blood pressure ☐ weight ☐ waist circumference ☐ total cholesterol ☐ LDL-cholesterol ☐ HDL-cholesterol ☐ triglycerides ☐ other:

Check the ONE statement that BEST pertains now, at start of program	End of program	Change	
☐ I do not plan to make changes in my diabetes care in the **next 6 months.**	☐		PC
☐ I plan to make changes in my diabetes care in the **next 6 months.**	☐		C
☐ I plan to make changes in my diabetes care in the **next month.**	☐		P
☐ I have made changes in my diabetes care in the **last 6 months.**	☐		A
☐ My diabetes has been in good control for **more than 6 months.**	☐		M
☐ My diabetes has been in good control and then went out of control.	☐		R

HEALTH CARE UTILIZATION IN PAST 12 MONTHS

Health insurance plan(s):

Insurance pays for: ☐ glucose meter ☐ strips ☐ lancets ☐ diabetes medication ☐ insulin pump ☐ CGM

☐ diabetes shoes ☐ lab tests ☐ doctor visits ☐ diabetes education ☐ medical nutrition therapy ☐ not sure

Number of: Hospital stays = ER visits = Doctor visits = Outpatient visits =

Previous diabetes education: ☐ no ☐ yes Dietitian visits: ☐ no ☐ yes

DIABETES ATTITUDES and BELIEFS

Your knowledge of diabetes and its control is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Your confidence in actually being able to control your diabetes is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Do you feel that good control is worth it? ☐ no ☐ yes ☐ not sure

Your feelings about having diabetes: ______________________________

Do you feel that diabetes is serious? ☐ no ☐ yes ☐ not sure

DIABETES HISTORY and CURRENT STATUS

Diabetes diagnosed in year: **Type of diabetes:** ☐ type 2 ☐ type 1 ☐ gestational ☐ not sure

Do you carry diabetes identification? ☐ no ☐ yes Type of identification:

Do you examine your feet? ☐ no ☐ yes If yes, how often? ☐ daily ☐ weekly ☐ monthly ☐ occasionally

A1C test results: **Date:** _________ **Value:** _________ ☐ UNKNOWN

I test my blood sugar ___times a: ☐ day ☐ week ☐ month ☐ don't test Record results? ☐ yes ☐ no ☐ sometimes

Brand name of my blood glucose meter: How old is meter? ☐ not sure

I test: ☐ fasting/before breakfast ☐ before lunch/dinner ☐ after meals ☐ bedtime ☐ 2-3 a.m. ☐ other:

Test results: ☐ fasting/before breakfast = ☐ before lunch/dinner =

☐ after meals = ☐ bedtime = ☐ 2-3 a.m. = ☐ other =

Had recent episodes of: ☐ high blood sugar coma ☐ diabetic ketoacidosis
☐ high blood sugar (250 or more)…….Occurs about _________ times a month
☐ low blood sugar (69 or less)………Occurs about _________ times a month
☐ ketones in urine……………………..…..Occurs about _________ times a month

Diabetes has caused a **problem** in these areas of my life: ☐ family life ☐ social activities ☐ work/school ☐ travel ☐ finances ☐ sports/exercise ☐ sexual relations ☐ peace/contentment ☐ everyday activities ☐ other:

Have history of:

☐ eyes/vision problems___________ ☐ heart/artery disease___________ ☐ protein in urine________________
☐ numbness/sensations___________ ☐ stroke______________________ ☐ other diabetes problems:
☐ kidney problems_______________ ☐ dry or itchy skin_____________
☐ feet/toenail problems___________ ☐ amputation__________________
☐ teeth/gum problems____________ ☐ stomach problems____________
☐ poor leg circulation____________ ☐ bowel problems______________
☐ frequent infections…where?_________________________ ___________

Do you get annual flu shot? ☐ no ☐ yes ☐ not sure Did you get pneumonia shot? ☐ no ☐ yes ☐ not sure

Stress level (circle #): 1 2 3 4 5 (highest) How you deal with it:

CULTURAL and RELIGIOUS FACTORS

Special dietary customs, needs, observances (including fasting from food):

Other cultural or religious practices that may affect your diabetes self-care:

MEDICAL HISTORY and OTHER MEDICATIONS

Specialists seen in last year for: ☐ dilated eye exam ☐ foot exam ☐ dental check-up and teeth cleaning

Also see specialists for: ☐ mental health ☐ kidneys ☐ hearing/ears ☐ skin ☐ other:

My overall health is: ☐ good ☐ fair ☐ poor ☐ not sure

Have you ever or do you now have any of the following:

☐ high blood pressure ☐ high cholesterol ☐ high triglycerides ☐ constipation ☐ diarrhea ☐ arthritis
☐ thyroid disease ☐ depression ☐ mental health problems ☐ pain or fatigue syndromes ☐ osteoporosis
☐ cancer If yes, Type: ________________

Please list all surgeries and date:

Type: Date:

________________________ ______________

________________________ ______________

________________________ ______________

________________________ ______________

________________________ ______________

________________________ ______________

☐ other:

WOMEN ONLY
No. of pregnancies = No. children born alive = Birth weights =
Pregnancy complications:
Did you have gestational diabetes? ☐ yes ☐ no ☐ don't know
Sexual problems: ☐ vaginal dryness ☐ loss of libido ☐ other: Plans to get pregnant? ☐ yes ☐ no ☐ maybe
Are you pregnant? ☐ yes ☐ no ☐ maybe If yes, pre-pregnancy wt: No. weeks pregnant = Due date =

MEN ONLY
Sexual problems: ☐ impotence ☐ loss of libido ☐ other:

BEING ACTIVE and OTHER LIFESTYLE HABITS
Do you exercise? ☐ no ☐ yes Type of:
How often? How long each time? OK'd by doctor? ☐ yes ☐ no
Do you smoke? ☐ yes ☐ no How long? No. of: ☐ packs ☐ cigarettes ☐ cigars a day =
Do you drink alcohol? ☐ yes ☐ no How long? No. of drinks: ☐ per week or ☐ per day is =

Please turn to next page to list medications, or bring detailed medication list to appointment.

Medications: (list ALL medications; prescription/over the counter & herbals)

Allergies: ________________________________

NAME	**DOSE** (# mg)	**FREQUENCY** (how often)