Gwinnett Hospital System

PLACE LABEL HERE

DIABETES EDUCATION PATIENT ASSESSMENT

Please fill out this form to help your diabetes educator learn about you.

PATIENT INFORMATION	
Name:	Diabetes Diagnosis Date:
Primary Language: ❑ English ❑ Other:	Occupation:
Education / Last Grade Attended:	

LEARNING
Preferred Method: ❑ Reading ❑ Lecture/Audio ❑ Hands On Demonstration ❑ Video ❑ Group Discussion
What is most important to you to learn about taking care of diabetes?

BLOOD GLUCOSE MONITORING	
Do you check your blood glucose? ❑ Yes ❑ No	What type of meter do you use?
Frequency per day: ❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ more than 4x ❑ Every Other Day ❑ Occasionally ❑ Rarely	

DIABETES SPECIFIC	
Family History of Diabetes? ❑ Yes ❑ No	Who has Diabetes?
Visit to Emergency Room or Hospital in the last 6 months? ❑ Yes ❑ No	
Reason for visit:	

FEMALE SPECIFIC	
Did you have diabetes during pregnancy? ❑Yes ❑No	Are you currently pregnant? ❑Yes ❑No

OTHER MEDICAL HISTORY	
Check all areas in which you have any problems or have received medical treatment and briefly explain	
❑ Skin: (including excessive dryness, itchiness, and slow wound healing)	❑ Intestines/Digestion: (including chronic diarrhea, constipation, ulcers, and reflux)
❑ Eyes: (including eye disease and blindness)	❑ Groin/Sexual Organs: (including impotence, dryness, and chronic yeast infections)
❑ Nerves: (including nerve disease and neuropathy)	❑ Circulation/Blood Pressure: (including high blood pressure and stroke)
❑ Thyroid: (including hyper- and hypothyroidism)	❑ Arms/Legs: (including tingling, numbness, and pain)
❑ Kidneys/Bladder: (including kidney disease)	❑ Feet: (including foot ulcer and infection)
❑ Heart: (including high cholesterol, congestive heart failure, heart attack)	❑ Other: (including pain)

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SELF CARE BEHAVIOR

Do you have a history of tobacco use? ❑ Yes ❑ No	Do you currently smoke? ❑ Yes ❑ No
How much per day? ❑ less than 5 ❑ ½ pack ❑ 1 pack ❑ more than 1 pack ❑ Occasionally	
Do you drink alcohol? ❑ Yes ❑ No	How much per day? ❑ Less than 1 drink ❑ 1-2 drinks ❑ more than 3 drinks

MEALS AND DINING

Do you have any cultural or religious dietary practices? ❑ Yes ❑ No Please Specify:

List any recent changes in your eating habits:

List any special food considerations in developing a meal plan for you:

Please write out what you eat in a typical day:

Morning (Breakfast) Time:	Mid-morning Time:	Mid-Day (Lunch) Time:
Mid-Afternoon Time:	Evening (Dinner) Time:	Before Bed Time:

PHYSICAL ACTIVITY

Do you participate in regular physical activity? ❑ Yes ❑ No

What type?	How Often?

PATIENT SELF-ASSESSMENT

How would you rate your understanding of diabetes? ❑ Good ❑ Fair ❑ Poor

Feelings about Diabetes: ❑ Denial ❑ Sadness/Depression ❑ Anger ❑ Fear ❑ Guilt ❑ Overwhelmed/Confused ❑ Adaptation ❑ Acceptance

How would you rate your overall health? ❑Good ❑ Fair ❑ Poor	What is a healthy weight for you?

How would you rate your stress level? ❑ High ❑ Medium ❑ Low

Diabetes Interferes With: ❑ Nothing ❑ Family/Social Activities ❑ Work/School ❑ Sports/Exercise ❑ Finances ❑ Sexual Relations ❑ Travel ❑ Other:

Do you carry identification that states you have diabetes? ❑ Yes ❑ No

Signature	Date	Relationship to patient

Reviewed by:

INITIALS	NAME & TITLE	DATE & TIME