Diabetes Education at JMC

JUPITER MEDICAL CENTER

PATIENT INITIAL ASSESSMENT-DIABETES

Name _____ **Date**_____
Address_____
Phone: Home (_____) _____ Work: (_____) _____ Mobile: (_____) _____
Date of Birth ___/___/___ **Age**_____ **Gender**: F__ M__ **Weight**_____ **Height**_____ **Goal Weight** _____
Ethnic Background: White/Caucasian___ Black/A-A ___ Hispanic ___ Native American___ Middle-Eastern___

Please answer the following questions:

1. **Marital Status:** Single___ Married___ Divorced___ Widowed___ Significant other____
   Number in household: ____ **Relation to you** _____
   You receive support from (check all that apply): Family ___ Co-worker(s) ___ Healthcare provider(s) ___
   Support Group ___ No one___

2. **Currently employed:** N___ Y___ **Occupation** _____ **Work hours**_____
   Primary Language: English____ Spanish___ Other _____
   Highest grade completed _____
   Type of assistance needed (check all that apply): Visual___ Hearing___ Reading___
   Physical Limitation___ Other _____

3. **Type of diabetes:** Type 1____ Type 2____ Pre-diabetes____ GDM____ Don't Know____
   Year/Age of Diabetes Diagnoses_____/_____ **Relatives with diabetes** _____
   What is diabetes? _____ **Previous diabetes education**: N___ Y___

4. **Diabetes medications taken** (check all that apply)**:** Diabetes pills ___ Insulin injections ___
   Byetta injections___ Symlin injections___
   Combination of pills and injections___ None___
   Have you ever forgotten to take your diabetes medications? N___ Y ___
   If so, what do you do? _____
   If you take insulin: Where do you store it? _____ Injection site _____
   Disposal site/method _____ Who gives injection? _____
   Method: Syringe___ Insulin pen___ Insulin pump___ **Do you reuse syringes?** N___ Y___
   Do you have a sliding scale? N___ Y___ (provide copy)

5. **Do you check your blood sugars?** N___ Y___ **Frequency** (times per day/week) _____
   When: Before breakfast___ 2 hours after meals___ Before bedtime___
   Other_____
   Results: Morning_____ Noon_____ Evening _____ Bedtime_____ **Do you keep a record?** N___ Y___

6. **Please provide information on your abnormal blood sugar levels within the last 3 months:**
   Low blood sugar: Frequency_____ Time of day _____ Blood Sugar Level _____
   Symptoms _____Treatment _____
   Do you have a glucagon kit? N___ Y___ If yes, when do you use it? _____
   High blood sugar: Frequency_____ Time of day _____ Blood Sugar Level _____
   Symptoms _____Treatment _____
   Do you wear a medical ID? N___ Y___ **Do you test for ketones?** N___Y ___ Frequency_____

7. **Do you have?** (check all that apply)**:** Eye Problems___ Kidney Problems___ Heart Disease___
Numbness/tingling/loss of feeling in feet___

8. **Do you smoke?** N___ Y___ What_____ Frequency _____ How long_____
Do you drink alcohol? N___ Y___ Type: _____ Frequency _____
Caffeine: N___ Y___ What? _____ How much_____
Do you exercise regularly? N___ Y___ Type: _____ Frequency_____
Exercise routine difficulty level: Easy___ Moderate___ Intense____ Very Intense___

9. **Medical conditions**: High Blood Pressure___ High Cholesterol___ High Triglycerides____ Allergies_____
Dental Problems___ Sexual Problems___ Depression___
Other_____
Are you planning a pregnancy? N___ Y___ If yes, when? _____ Not Applicable ___
Have you ever been pregnant? N___ Y___ If yes, how many times?_____ Not Applicable ___
Do you have children? N___ Y___ Ages: _____
Are you aware of the impact of diabetes on pregnancy? N___ Y___ **Do you use birth control?** N___ Y___

10. **How often do you see a doctor for**: Eye exam_____ Glasses/contact lenses _____
Dental exam_____ Routine diabetes visit_____
Foot care_____ other_____
How many hospital stays in the past year? _____ **Emergency room visits?** _____

11. **Please state whether you agree, are neutral or disagree with the following statements:**
I feel good about my general health: agree___ neutral___ disagree___
My diabetes interferes with other aspects of my life: agree___ neutral___ disagree___
My level of stress is high: agree___ neutral___ disagree___
How do you handle it?_____
I have some control over whether I get diabetes complications or not: agree___ neutral___ disagree___
I struggle with making changes in my life to care for my diabetes: agree___ neutral___ disagree___
What is the most difficult thing about having diabetes? _____
List a learning Goal _____
How do you learn best: Listening_____ Reading_____ Observing_____ Doing _____

12. **Do you have any cultural/ religious practices or beliefs that influence how you care for your diabetes?**
N___ Y___ Please explain _____

13. **Do you have a meal plan for diabetes?** N___ Y___ If yes, describe _____
Who shops for your food? _____ **Who prepares your food?** _____
Do you eat fried foods? N___ Y___ Frequency _____
Diet restrictions: Salt___ Fat___ None___ Other _____
Portion sizes: Small____ Average____ Large_____
How fast do you usually eat? Slowly _____ Average_____ Fast_____
How do moods or stress affect your eating habits: Increases ___ Decreases ___ No affect___
Meals consumed per day_____ **Snacks per day**_____ what kind_____
Do you skip meals? N___ Y___ which one(s)_____
Do you eat dessert? N___ Y___ frequency and type of dessert:_____
How often do you eat out? _____
List the types of restaurants or fast food: _____

Give a sample of your meals for a typical day:

Time: _____ Breakfast: _____

_____

Time: _____ Lunch: _____

_____

Time: _____ Dinner: _____

_____

Time: _____ Snack: _____

Time: _____ Snack: _____

Time:_____ Snack:_____