SENTARA
eCare Health Network

Patient Label

Diabetes Self Management Training

ASSESS

Please complete this Assessment form and bring with you to your 1st diabetes class.

Name_____
Last First Middle Initial

Address_____
Street No. City State Zip

Phone (_____)_____e-mail _____

Doctor's Name_____ Phone (_____)_____

Address_____
Street No. City State Zip

Diabetes / Health History

Race: ☐White ☐Black ☐Native American/Eskimo ☐Hispanic ☐Asian/Pacific Island ☐Other:
Multiracial: ☐Yes ☐No

Birth Date: | **Age at diagnosis of diabetes:**

Diabetes Type: ☐ Type 1 ☐ Type 2 (treated with insulin) ☐Type 2 (treated without insulin)

Medications:
Diabetes Medicine:
Name Dosage: Time:
Name Dosage: Time:
Name Dosage: Time:
Other Medicines:

Please list any over the counter meds, herbal supplements or vitamins you take.

Do you have a blood glucose meter? Name of meter:
How often do you check your blood glucose?

Do you have low blood sugars? When? How often?
How do you feel if your blood sugar is low?
How do you treat these?

Have you been hospitalized in the last year for diabetes? Y / N Emergency room visits? Y / N

Lab Values (If known)

Fasting Blood Sugar:	HgbA1c:	Cholesterol:	Triglycerides:
HDL:	LDL:	Microalbumin:	

Do you have any of the following complications? (check all that apply)

☐Blindness
☐Blurred Vision
☐Retinopathy (eyes)
☐ Previous Laser Surgery
☐Kidney Disease/Dialysis
☐Heart Attack/Stroke
☐Heart Disease
☐High Blood Pressure
☐Sexual Difficulties
☐Digestive Problems
☐Dental/Gum Problems

Do you have any of the following problems with your feet? (check all that apply) ☐ Burning
☐ Foot Deformity ☐ Foot/Leg Amputation ☐ Fungal Toenails ☐ Numbness ☐ Pain ☐ Sores (ulcers)
☐ Tingling ☐ Other: **Do you check your feet daily? Y / N**

Diet, Exercise and Social History

Previous diabetes education: Y / N Where? How long ago?

Have you received a meal plan from a dietitian? Y / N If yes, indicate what type of meal plan you use:
☐Exchange List ☐Carbohydrate Counting ☐Calorie Counting (calorie amount): ☐Other: (please describe)

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Please check any of the following that make it hard for you to learn.

☐Vision ☐Hearing ☐Writing ☐Physical Problems
☐Pain ☐Reading ☐Language ☐Other:

Height: **Present weight:** **What do you think you should weigh?**
Any recent weight changes? **Gain / Loss** **How much?**

Do you have any food allergies / intolerances? Please list:

Do you eat meals at regular times each day? (Please list times)

Are your eating habits different on weekends? (Please explain)

Who prepares your meals?

How often do you eat out? **Where?**

Do you eat snacks? (please circle) Mid-Morning Mid-Afternoon Bedtime Late night

From the foods listed below, please circle those that you eat or drink:

Milk (type:_____)	Salads	Fish / Shellfish	Ice Cream
Cold Cereal	Pasta/Potatoes/Rice	Eggs	Fruit Juices
Cooked Cereal	Cooked vegetables	Peanut Butter	Vegetarian
Breads / Crackers	Chicken / Turkey	Cheese	Yogurt
Fresh Fruits	Beef / Pork	Favorite Foods (please list):	

Do you exercise regularly? **How often?** **Time of day?**
Type of exercise:
What affect does exercise have on your blood sugar?

Occupation: **Who lives with you?**

Who helps you deal with having diabetes, besides your doctor?

Do you use tobacco? Y / N ☐Cigarettes ☐Cigars ☐Pipe ☐Chewing Tobacco ☐Snuff

Do you consume alcohol? Y / N **If yes, how often?** **How much?**

Problem Solving: Cultural/Religious/Social Factors that impact how you control your diabetes (such as fasting, special foods, money concerns):

What habits do you have that you know are not good for your Diabetes?

What concerns you most about your diabetes?

What do you hope to learn about diabetes?

How do you rate your overall health? (Please check)
☐Excellent ☐Good ☐Fair ☐Poor

On a scale of 0-3, please rate your success at being able to:
(0 = do not know 1 = no success 2 = some success 3 = great success)
___ Control Blood Sugar ___ Control BP ___ Handle Change ___ Improve Risk Factors
___ Manage Diabetes (overall) ___ Manage Illness with Diabetes ___ Manage Stress

Date_____ Diabetes Educators _____

_____