SENTARA
eCare Health Network

Patient Label

Diabetes Assessment

ASSESS

Diabetes / Health History

When were you diagnosed?

Diabetes Type: ☐ Type 1 ☐ Type 2 ☐ Diabetes in pregnancy

Family history of Diabetes? ☐ Yes ☐ No

Who?

Do you test your blood sugar? ☐ Yes ☐ No_____ Most recent hemoglobin A1C: _____

When do you test? _____

Usual readings? _____

Do you test your urine for ketones? ☐ Yes ☐ No

Any episodes of Diabetic Ketoacidosis? ☐ Yes ☐ No

Has your blood sugar been over 350 mg/dL? ☐ Yes ☐ No

When/how often? _____

Has your blood sugar been below 70 mg/dL? ☐ Yes ☐ No

When/how often? _____

Health Status:

Height: _____ Current Weight: _____ Body Mass Index: _____

Any recent weight gains or losses? _____ Goal Weight: _____

Medications: Are you allergic to any medications? ☐ Yes ☐ No List: _____

Do you take any medications for diabetes? ☐ Yes ☐ No List: _____

_____

Do you take any other medications, supplements, or herbs? ☐ Yes ☐ No List: _____

_____ _____

_____ _____

Do you have any difficulty affording your medications? ☐ Yes ☐ No Describe: _____

Medical History

Heart/Vascular Disease	☐ Yes ☐ No	HIV/Blood disorders	☐ Yes ☐ No	Past Surgeries	☐ Yes ☐ No
History of stroke	☐ Yes ☐ No	Depression/anxiety	☐ Yes ☐ No	List: _____	
High blood pressure	☐ Yes ☐ No	Eye problems	☐ Yes ☐ No	_____	
_____ / _____		Numbness, tingling,	☐ Yes ☐ No	_____	
Cancer	☐ Yes ☐ No	pain in hands/feet		_____	
Arthritis	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No	Other	☐ Yes ☐ No
Skin problems	☐ Yes ☐ No	Foot problems	☐ Yes ☐ No	_____	
Asthma/Sleep Apnea	☐ Yes ☐ No	Frequent infections	☐ Yes ☐ No	_____	
Thyroid	☐ Yes ☐ No	Slow healing wounds	☐ Yes ☐ No	_____	
Gastrointestinal	☐ Yes ☐ No	Chronic pain	☐ Yes ☐ No	_____	

Women: Sexuality/Reproduction

Currently pregnant? ☐ Yes ☐ No How many weeks? _____ Estimated due date: _____

Any complications during pregnancy or delivery? ☐ Yes ☐ No List: _____

Number of pregnancies: _____ Number of live births: _____ Date of last period: _____

Current contraception: _____ Plans for pregnancy in the future? ☐ Yes ☐ No

Experiencing any sexual problems (circle): vaginal dryness loss of libido UTI yeast infection none other: _____

Men: Sexuality/Reproduction

Experiencing any sexual problems (circle): prostate issues erectile dysfunction urinary problems none other: _____

Healthcare Utilization

Have you been admitted to the hospital or gone to the emergency room within the past 12 months? ☐ Yes ☐ No

Number of visits: _____ Reasons: _____

Who is your primary care physician? _____ When was your last visit? _____

Who is your endocrinologist? _____ When was your last visit? _____

Do you see other specialists? ☐ Podiatrist Last visit? _____ ☐ Cardiologist Last visit? _____

☐ _____ Last visit? _____ ☐ _____ Last visit? _____

Frequency of eye/retinal exams: _____ Frequency of dental exams/cleanings: _____

Have you ever had diabetes education? ☐ Yes ☐ No When? _____ Where? _____

Who referred you to this program? _____

Eating Habits

Currently on a diet? ☐ Yes ☐ No Describe: _____

Food allergies? ☐ Yes ☐ No List: _____

Appetite is: ☐ Good ☐ Fair ☐ Poor Primary cook and shopper: _____

How often do you dine out? _____ Where do you go? _____

Meals per day: _____ Snacks: _____

Risk Factors

Do you smoke? ☐ Yes ☐ No For how long? _____ # of packs per day? _____

Do your drink alcohol? ☐ Yes ☐ No Type? _____ # of drinks per week? _____

Use recreational drugs? ☐ Yes ☐ No Describe: _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No Describe: _____

How long? _____ How often? _____

Physical limitations: _____

Support System

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed Number of people living in household: _____

Primary support person: _____

Any major stressors in your life? _____

Date: _____ Patient Signature: _____

Educator Signature: _____ For office use only: ☐ Reviewed ☐ Completed with patient

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Socioeconomic

Currently employed? ☐ Yes ☐ No Occupation: _____

Retired? ☐ Yes ☐ No Previous occupation: _____

Number of years of schooling: _____

Primary language: _____ Do you need an interpreter? ☐ Yes ☐ No

How do you learn best? ☐ Reading ☐ Listening ☐ Demonstrations ☐ Other _____

Any barriers to learning? ☐ Visual ☐ Auditory ☐ Literacy ☐ None ☐ Other: _____

Cultural Factors

Any special dietary needs due to religion? ☐ Yes ☐ No Describe: _____

Any religious observances that affect lifestyle? ☐ Yes ☐ No Describe: _____

Health Beliefs, Goals and Attitudes

How do you feel about your overall health? Having diabetes? _____

Goals for education session: _____