JUPITER MEDICAL CENTER

DIABETES EDUCATION INTAKE ASSESSMENT

Name: _____ Date: _____
Date of Birth: _____Height _____ Weight _____ Goal Weight _____

DIABETES HISTORY

What type of Diabetes do you have? Type 1 ☐ Type 2 ☐ Pre Diabetes ☐ Gestational ☐ I do not know ☐
Year/Age of Diabetes Onset _____
Ethnic Background: Am Indian/Alaskan Native ☐ Black/African Am ☐ White/Caucasian ☐
Asian/Japanese/Chinese/Korean/Pacific Islander ☐ Hispanic/Cuban/Chicano/Mexican/Puerto Rican ☐
Middle Eastern ☐

WOMEN OF CHILD BEARING AGE:
Are you pregnant? No ☐ Yes ☐ If yes, when are you due? _____
Are you planning a pregnancy? No ☐ Yes ☐ When?_____
Are you aware of the impact of diabetes on pregnancy? No ☐ Yes ☐ Are you using birth control ? Yes ☐ No ☐

FOR GESTATIONAL DIABETICS ONLY:
Pregnancy History: # of Pregnancies _____ # Live Births _____ Pre-pregnant weight _____
Previous complications related to pregnancies: _____

DIABETES EDUCATION NEEDS

Do you have a support person (s)? Yes ☐ No ☐ Support person(s) name/relationship _____
Do you know how to manage your diabetes while sick? Yes ☐ No ☐
I have a Diabetes ID with me or available? Yes ☐ No ☐
Describe your current feelings about having diabetes: Sad ☐ Angry ☐ Worried ☐ Burdened ☐ Frustrated ☐
Accepting ☐ Distressed ☐ Frightened ☐ Discouraged ☐ No feelings ☐ Other _____
My memory is: Good ☐ Fair ☐ Poor ☐
How do you learn best: Listening ☐ Reading ☐ Observing ☐ Doing ☐ On Computer ☐ Other _____
Which describes how you feel about learning: Excited ☐ Ready to start ☐ Thinking about it ☐ Not ready ☐
Previous Diabetes Education? No ☐ Yes ☐ Details about education _____
Need Assistance with: Visual Impairment ☐ Hearing ☐ Reading ☐ Physical Limitation _____
What language do you speak/write most often? _____
Financial Difficulties ? Food ☐ Medications ☐ Testing/monitoring supplies ☐ Transportation ☐
Do you have any cultural/religious practices or beliefs that influence how you care for your diabetes? No ☐ Yes ☐
Please explain _____
Hospital stay within the last year? No ☐ Yes ☐ Give details of hospitalization _____
Number of ER visits or 911 calls within the last 3 months? _____

DIABETES TREATMENT OVERVIEW

Current Treatment: None ☐ Diet only ☐ Oral agents ☐ Insulin pen ☐ Insulin vial ☐ Insulin Pump ☐
CGM with pump ☐ Other type of injection please list: _____
Describe how you take your medication: Take as prescribed ☐ Rarely miss a dose ☐ Miss a lot of doses ☐
What do you do if you miss a dose? _____


3PA

IF YOU TAKE INSULIN

Where do you store it? _____ How do you dispose of it? _____
What areas of body do you use for injection? _____ Who gives the injection? _____
Do you use a sliding scale? No ☐ Yes ☐ Do you reuse syringes? No ☐ Yes ☐

GLUCOSE MONITORING

Do you check your blood sugars? No ☐ Yes ☐
How often do you check? Once daily ☐ Twice daily ☐ Three times daily ☐ Four times daily ☐ Other _____
When: Before Breakfast ☐ 2 hours after meals ☐ Before Bedtime ☐ Other _____
Results: before meal _____ after meal _____ bedtime _____
Do you keep a record? No ☐ Yes ☐
Have you had a **low blood sugar** in the last 3 months? No ☐ Yes ☐ How often? _____
What time of day _____ At what number? _____ Symptoms _____ Treatment _____
Do you have a glucagon kit? No ☐ Yes ☐ If you have used it, when was last time? _____
Have you had **a high blood sugar** in the last 3 months? No ☐ Yes ☐ How often? _____
What time of day _____ At what number? _____ Symptoms _____ Treatment _____
Do you test for ketones? No ☐ Yes ☐

EYE, FOOT, DENTAL ASSESSMENTS

Yearly dilated eye exam? No ☐ Yes ☐ Date of last exam? _____ Blurry or difficulty seeing? No ☐ Yes ☐
Glasses /contact lenses? No ☐ Yes ☐
Yearly Dental Exam? No ☐ Yes ☐ Date of last exam? _____ Dental problems No ☐ Yes ☐ _____
Yearly Foot Exam? No ☐ Yes ☐ Date of last exam? _____ Numbness/tingling/loss of feeling in feet No ☐ Yes ☐
Barriers to caring for feet? _____

EXERCISE

Do you exercise regularly? No ☐ Yes ☐ Type of exercise? _____ How often? _____
Intensity of my work out is: Light ☐ Moderate ☐ Intense ☐ Barriers to exercising? _____

MEDICAL CONDITIONS/PROBLEMS

Please check all that apply:
Eye problems ☐ Kidney disease ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycericles ☐
Anxiety ☐ Depression ☐ Sexual problems ☐
Allergies? No ☐ Yes ☐ Please list _____

SOCIAL HISTORY

Do you Smoke: No ☐ Yes ☐ # years _____ # packs of cigarettes _____
Do you drink alcohol? No ☐ Yes ☐ Type & amount of alcohol? _____ How many drinks/week? _____
Do you drink caffeine? No ☐ Yes ☐ How many cups/day? _____
Vitamin Supplements? No ☐ Yes ☐
Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other's name: _____
Do you feel safe at home? Yes ☐ No ☐ _____
Currently employed? Employed ☐ Part time ☐ Retired ☐ Unemployed ☐ Student ☐ Occupation _____
Highest Grade completed? _____
Do you have any family members with Diabetes? No ☐ Yes ☐ _____

For Office Use Only:
Numeracy and Health Literacy Comments: _____

NUTRITION ASSESSMENT

Do you have a meal plan for diabetes? No ☐ Yes ☐ If yes, describe _____
Do you have diet restrictions? No ☐ Yes ☐ If yes: Salt ☐ Fat ☐ Other _____
Do you eat out? No ☐ Yes ☐ If yes, # times/week ? _____ Type of restaurant? _____
# of members in the household? _____ Please list: _____
Who does the shopping? _____ Who does the cooking? _____
How is your food prepared? Fried ☐ Baked ☐ Broiled ☐ Grilled ☐ Gravy /Sauces ☐
My portions are: Small ☐ Average ☐ Large ☐
I eat Slow ☐ Average ☐ Fast ☐ # of minutes to finish a meal _____
Hunger symptoms? _____
My mood/stress increases my eating ☐ decreases my eating ☐ does not affect my eating ☐
Meals consumed per day: _____ Snacks per day? _____ What kind? _____
I eat desserts: # of times/week _____ or # of times/month _____
I skip meals: No ☐ Yes ☐ Which meal do you skip? _____

Give a sample of your meals for a typical day: Indicate portion sizes!

Time: _____ Breakfast _____

_____

Time: _____ Lunch _____

_____

Time: _____ Dinner: _____

_____

Time: _____ Snacks _____

Time: _____ Snacks: _____

Time: _____ Snacks: _____

JUPITER MEDICAL CENTER

Patient Name: _____ Date: _____

Medication Allergies: _____

Not Taking Any Medications ☐

MEDICATION LIST

LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS			
Name of Medication	**Dose**	**How is it taken? Pill or injection**	**How often is it taken**