Diabetes History Form

General Information
1. Education Major ___________________________ Expected Graduation _______________________
2. Marital Status  □ Single  □ Married  □ Other ___________________________
3. How many people live in your household? ___________________________
4. Is there anyone who will help you in your diabetes care?  □ Yes  □ No    If yes, who ___________________________
5. Do you work outside of taking classes?  □ Yes  □ No  Where ___________________________ Hours/week _______________________
6. Diabetes provider at home ___________________________ Phone _______________________

Diabetes History
1. How long have you had diabetes? ________ What type?  □ Type 1  □ Type 2  □ Gestational  □ Unknown
2. List any family members with diabetes ___________________________
3. How would you rate your understanding of diabetes?  □ Good  □ Fair  □ Poor
4. What areas of diabetes would you like to learn more about?
   □ Diet  □ Stress  □ Blood testing  □ Low blood sugar  □ Insulin pumps  □ Pills for diabetes
   □ Exercise  □ Sick days  □ Complications  □ High blood sugar  □ Pregnancy and diabetes
5. How do you learn best?  □ Written material  □ Verbal discussion  □ Hands on
6. What is your goal for this session?  □ Learn more about diabetes  □ Help with meal planning
   □ Better blood sugar control  □ Weight management

Nutrition
1. Has your weight changed in the last 3 months?  □ Yes  □ No    I have  □ Gained  □ Lost ________ lbs.
   Was this weight change intentional?  □ Yes  □ No
2. How many times do you eat per day?  Meals ____________ Snacks ____________
3. How often do you eat/drink the following? (per week)
   _______ Fruits  _______ Vegetables  _______ Sweets  _______ Fast Food  _______ Milk (fat free, 1%, 2%, whole)
   _______ Juices  _______ Cheese  _______ Alcohol  _______ Water
4. How often per week do you eat away from home? ____________ Where ___________________________
5. How is your food prepared?  □ Fried  □ Baked  □ Broiled  □ Grilled
6. How would you describe your portions?  □ Small  □ Average  □ Large
7. Any special diet needs or practices?
8. Have you ever been told you have  □ High cholesterol  □ High triglycerides  □ High blood pressure
9. What diet plan do you typically follow?  □ Carb counting  □ Calories a day  □ Other _______________________
10. How is your insulin dosage calculated?  □ N/A  □ ________ Carbs to ________ units insulin (type ________)
    □ Fixed dose per meal (type ________)
    □ Adjustable dose dependent on blood glucose.
11. Complete the food history table below including amount and how typically prepared

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<th>Breakfast</th>
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Medication
1. If you take insulin: (if no skip to 6)
   Do you use?  □A syringe  □Insulin pen  □Insulin pump  □Insulin inhaler
2. What injection sites are used?
3. Where do you keep your insulin?
4. Do you reuse your syringes?  □Yes  □No  How many times before disposal?
5. How/where do you dispose of your syringes?
6. Do you use pills for your diabetes medication?  □Yes  □No  If yes, list amount and frequency below:

Monitoring
1. Do you test your urine:  For sugar?  □Yes  □No  For ketones?  □Yes  □No  How often?
2. Do you test your blood sugar?  □Yes  □No  How often?  Typical results
3. Do you keep a record of your results?  □Yes  □No

Exercise
1. Do you exercise regularly?  □Yes  □No  What type?
   How often?  For how long?
2. List any problems you have with exercise:

Complications
1. If you have ever had a low blood sugar reaction?  How did you feel?
   How did you treat it?  How often has this occurred?
2. Do you carry a source of sugar with you?  □Yes  □No
3. Have you ever had to be given glucagons?  □Yes  □No
4. If you have ever had High blood sugar:  How did you feel?
   How did you treat it?  How often has this occurred?
5. What is your daily blood sugar normal range?
6. Are you aware of the long term complications of Diabetes?  □Yes  □No
7. Do you have any of the following?  □Eye problems    □Heart problems  □Kidney problems
   □Numbness/pain  □Sexual problems  □Dental problems
   Please Explain

Medical History
1. When was your last:  Physical?  Eye exam?  Dental exam?
2. Do you smoke?  □Yes  □No  If yes, how much?  For how many years?
3. Do you drink alcohol?  □Yes  □No  If yes, how much?
4. Have you ever been hospitalized with diabetes?  □Yes  □No  Number of times
5. Have you been in the emergency department because of your diabetes?  □Yes  □No  How many times
6. Do you wear a medical identification bracelet or necklace?  □Yes  □No
7. Have you ever had a Pneumonia vaccination?  □Yes  □No  When?
8. Have you received a Flu shot within the year?  □Yes  □No

Other
Please list any other information that you feel would be important for your provider to know that would assist them in treating you:

Patient’s Signature  Date

Provider’s Signature  Date  11/22/06: bah