ILLINOIS
McKinley Health Center

place label here

Name:
UIN:
Date:

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

Breakfast	Lunch	Dinner
Snack	**Snack**	**Snack**

(over)

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Diabetes History Form – page 2

place label here

Name:

UIN:

Date:

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 you 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_____