Diabetes Forms

Saint Luke's Health System

Diabetes Health Assessment

Name: _____ Birth date: _____ ☐ Male ☐ Female

Primary Physician: _____ Diabetes Physician: _____

Occupation: _____ Work hours: _____ Daytime phone: _____

An ADVANCE DIRECTIVE is a document stating your health care choices or naming someone to make the choices for you if you become unable to do so.

Would you like information on an Advance Directive? ☐ Yes ☐ No ☐ Information provided to patient/family

Medications

What type of diabetes medicines do you take? ☐ Pill(s) ☐ Insulin ☐ None

Please list diabetes medicines, dose and the time you take them: _____

_____

List all other medicines you take including vitamin/mineral/herbal supplements and over-the-counter products or ☐ list attached:

_____

_____

_____

List any allergies to medications: _____

Health History

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Don't know

How long have you had diabetes? _____ **Have you ever had diabetes education?** ☐ Yes ☐ No

If yes, where and how long ago: _____

Please indicate if you have any of the following medical problems or diabetes complications:

☐ Depression/Anxiety	☐ Skin infections	☐ Sexual function problems
☐ Heart disease	☐ Kidney problems	☐ High blood pressure
☐ High cholesterol	☐ Foot problems	☐ Thyroid problems
☐ Sleep apnea	☐ Vision problems	

☐ Numbness/tingling/pain in: ☐ Feet ☐ Legs ☐ Hands

☐ Low blood sugar *(weak/shaky/sweaty)* How often? _____

☐ Other *(please describe)*: _____

Have you been in the hospital in the past 6 months? If yes, why? _____

Please list any surgeries: _____

Last dilated eye exam: _____ Last dental exam: _____

Flu shot: ☐ Yes ☐ No If yes, when? _____ Pneumonia shot: ☐ Yes ☐ No If yes, when? _____

How often do you check your feet? ☐ Daily ☐ Weekly ☐ Monthly ☐ Only at Dr.'s Office ☐ Never

Blood Sugar Monitoring

Do you test your blood sugar? ☐ Yes ☐ No If yes, what type of meter do you use? _____

How often do you test? ☐ 1/day ☐ 2/day ☐ 3-4/day ☐ 1/week ☐ 2/week ☐ Other _____

What time of day do you test? _____

Do you know your last A1C result? ☐ Yes ☐ No If yes, what was it and when? _____

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Exercise – Lifestyle

Do you drink alcohol? ☐ Yes ☐ No If yes, number of drinks a week: _____
Do you use tobacco? ☐ Yes ☐ No If yes, number of cigarettes a day: _____
Do you exercise? ☐ Yes ☐ No If yes, what do you do? _____
How many times a week do you exercise? _____ How long? _____

Do you have any of the following feelings regarding your diabetes? (check all that apply)

☐ Frustration ☐ Anxiety ☐ Fear ☐ Depression ☐ Guilt
☐ Discouragement ☐ Stress ☐ Worry ☐ Anger ☐ Dealing Well

What are your main concerns about managing your diabetes? _____

Do you have any special learning needs? ☐ Vision problems ☐ Hearing loss ☐ Other: _____ ☐ None
Do you have special learning preferences? ☐ Demonstration ☐ Visual ☐ Hands on learning

What do you hope to gain from this appointment? ☐ Lose weight ☐ Improve blood sugars
☐ Improve eating habits ☐ Start exercising ☐ Carbohydrate counting ☐ Lower cholesterol/triglycerides
☐ Other: _____

Please put an "X" in the box that best describes how you feel about making changes in each area of your diabetes self-care routine:

	I have not thought about it much	I have thought about it, but have not started yet	I am ready to start making changes in the next month	I started doing this recently (within the past 6 months)	I have already been doing this for 6 months or more
Change eating habits					
Increase physical activity					
Monitor blood glucose					
Take medications regularly					

For Women:
Can you become pregnant? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No
Are you currently using birth control? ☐ Yes ☐ No What type? _____

Have you been kicked, punched, strangled or otherwise hurt by anyone in your household? ☐ Yes ☐ No

Is your partner, spouse, or anyone in your household threatening you or making you feel afraid? ☐ Yes ☐ No
METRO WIDE ABUSE HOTLINE 816-HOTLINE (816-468-5463) Safe Home 913-262-2868 www.safehome-ks.org

In the past two months would you say you have been feeling down, depressed or hopeless?
☐ Never ☐ Rarely ☐ Sometimes ☐ Mostly ☐ Always
In the past two months how often would you say you have been experiencing chronic pain?
☐ Never ☐ Rarely ☐ Sometimes ☐ Mostly ☐ Always Where? _____

Over the last two weeks have you had thoughts that you would be better off dead or hurting yourself in some way?
☐ Yes ☐ No
If yes,are you thinking about acting on any of these thoughts at this time? ☐ Yes ☐ No

Patient Signature:_____ Date/Time:_____

Diabetes Educator Signature:_____ Date/Time:_____

Patient Label:

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Diabetes Nutrition Assessment

Height: _____ Current weight: _____ What would you like to weigh? _____
Has your weight changed in the last 6 months? ☐ Yes ☐ No (*describe changes)* _____

Do you use any meal planning method now? ☐ Yes ☐ No *(please describe)* _____
How often do you follow your meal plan? ☐ Usually ☐ Sometimes ☐ Not at all
Do you have any cultural or religious food restrictions? ☐ Yes ☐ No *(specify)* _____
Do you have any other special dietary needs? ☐ High fiber ☐ Low cholesterol ☐ Low salt
☐ Other: *(please specify)* _____

Current Eating Habits (Please check all that apply):

☐ Skip meals	☐ Snack too often	☐ Eat too many carbohydrates/starches
☐ Eat too much at meals	☐ Eat too much when alone	☐ Poor appetite
☐ Eat too many sweets	☐ Binge eat	☐ Eat when depressed or stressed
☐ Eat out often How many times/week? _____		☐ Eat fried/greasy foods often

Who prepares your meals at home? ☐ Self ☐ Spouse ☐ Other: _____

Type of cooking methods used: ☐ Deep Fry ☐ Bake ☐ Grill ☐ Broil ☐ Microwave ☐ Stir Fry

How many times a week do you eat the following foods?

	Beef (hamburger, steak)		Yogurt		Vegetables
	Pork		Oil (type?)		Fruit
	Chicken/Turkey		Salad dressing (type?)		Fruit Juice
	Fish/Tuna/Salmon		Sour Cream/Cream cheese		Pie/Cake/Candy/Cookies
	Bacon/Sausage		Butter/Margarine		Ice Cream/FrozenYogurt/Sherbet
	Lunchmeat/Hotdogs		Beans/Lentils		Chips/Pretzels/Snack Crackers
	Peanut Butter		Bread (type?)		Alcohol (type?)
	Eggs		Cereal (type?)		Soda/Kool-Aid (regular or diet)
	Milk (type?)		Pasta/Rice		Coffee/Tea (with or without sugar)
	Cheese (type?)		Potatoes/French Fries		Water (How much?)

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Diabetes Nutrition Assessment

Food Record:

This food record will help your dietitian better understand how food affects your health and blood glucose levels.

- Start keeping your food record 2 days before your appointment.
- Please write down everything you eat and drink from the time you wake up to the time you go to bed.
- Include all meals, snacks and drinks (use other side if needed).

(Example) 8AM	1 cup 1 slice 1 small 1 cup	Oatmeal, cooked with water Whole wheat toast Banana Skim milk
Time	**Amount**	**Type of Food or Beverage**

Dietitian:_____ Date:_____ Time:_____

Patient Label: