ADULT DIABETES HISTORY

Name: 
Date Of Birth: 
Primary/Referring Physician: 
When were you diagnosed with diabetes?

Marital Status: 
- Single 
- Married 
- Divorced 
- Widowed 
- Separated 
- Cohabiting

# in household relationship

Will significant others participate in program?
- No
- Yes - relationships: Names:

Race (check all that apply)
- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Pacific Islander
- Spanish, Latino, or Hispanic

What level of schooling have you completed?
- Elementary School
- High School Diploma
- Some College
- College/University
- Technical/Vocational/Business
- Military Training
- Graduate School
- Other:

Have you ever had diabetes education?
- No
- Yes - Where? Date:

Do you have specific diabetes questions or goals for your education visits?
- No
- Yes - What are they?

Do you have any medication allergies?
- No
- Yes - Explain:

Have you ever been diagnosed with any of the following conditions, or do you have a concern?

<table>
<thead>
<tr>
<th>Diagnosed</th>
<th>Concerned</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>Eye or vision problems</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Kidney disease</td>
</tr>
<tr>
<td>Abnormal blood lipids</td>
<td>Skin Problems</td>
</tr>
<tr>
<td>Circulation problems</td>
<td>Dental or mouth problems</td>
</tr>
<tr>
<td>Numbness/Pain (hands/legs/feet)</td>
<td>Liver disease</td>
</tr>
<tr>
<td>Foot Problems</td>
<td>Stomach or bowel problems</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>Depression</td>
</tr>
</tbody>
</table>

Family History of:
- No
- Yes - Diabetes
- No
- Yes - Thyroid disease
- No
- Yes - Heart disease

List surgeries and/or hospitalizations with dates:

<table>
<thead>
<tr>
<th>Type of Surgery/Reason for Hospitalization:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Date of last eye exam
Date of last dental exam
Date of last foot exam

If you are female:

Are you pregnant? 
- No 
- Yes
Are you considering pregnancy? 
- No 
- Yes
Are you currently using birth control? 
- N/A 
- No 
- Yes
Type of birth control:

Are your menstrual cycles regular? 
- N/A 
- No 
- Yes
If no, Explain:
**NUTRITION AND LIFESTYLE HISTORY**

What food planning methods have you follow in the past? (check all that apply)

- Calorie counting
- Exchange lists
- Food pyramid/Healthy choices
- No specific plan
- Carb counting
- Fat gram counting
- No added sugar
- Low carbohydrate

Do you already have a prescribed meal plan or special diet from your doctor or dietitian?

How often do you follow a diabetes food plan?

- Never/Rarely
- Occasionally/sometimes
- Most of the time
- All of the time

Typical Day Schedule and Meals:
Please fill in the times of your meals and snacks, along with an example of the type and amount of food you might eat for your meals and snacks.

<table>
<thead>
<tr>
<th>Time:</th>
<th>USUAL MEALS-Example of food &amp; beverages in a typical day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>I get up at</td>
<td></td>
</tr>
<tr>
<td>Breakfast</td>
<td>Breakfast:</td>
</tr>
<tr>
<td>Morning snack</td>
<td>Morning Snack:</td>
</tr>
<tr>
<td>Lunch</td>
<td>Lunch/midday meal:</td>
</tr>
<tr>
<td>Afternoon snack</td>
<td>Afternoon snack:</td>
</tr>
<tr>
<td>Dinner</td>
<td>Dinner/Evening Meal:</td>
</tr>
<tr>
<td>Evening/Bedtime snack</td>
<td>Evening/Bedtime snack:</td>
</tr>
<tr>
<td>I go to bed at</td>
<td></td>
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</tbody>
</table>

Do you exercise?

- Yes
- No

What type(s)?

- Walking
- Biking
- Weights
- Sports
- Swimming
- Aerobic machine
- Yoga

How many times per week do you exercise?  
For how many minutes per time?

Have you ever been advised by a physician to limit your exercise in any way?

- Yes
- No

Is your job active or inactive?

- Active
- Inactive

Has your weight changed in the past year?

- Yes
- No

How much?

- Gain
- Loss

Do you use alcohol?

- Yes
- No

Type(s) amount, and times per week:

Do you use tobacco?

- Yes
- No

Type:

Amount per day:

Former tobacco user?

- Yes
- No

Quit date?

Do you use street drugs?

- Yes
- No

List all of your medications including over-the-counter medications & Vitamin/Mineral Supplements & Herbs

(Use separate paper if necessary)

<table>
<thead>
<tr>
<th>Oral Diabetes Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Date</td>
</tr>
<tr>
<td>-------------</td>
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<tr>
<td></td>
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</tbody>
</table>

Please describe any Side Effects
If you use insulin, please circle the types of insulin you are taking and your present insulin doses.

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
<th>Bedtime</th>
<th>Snacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humalog (Lispro)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Novolog (Aspart)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lantus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70/30 (with Aspart)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>70/30 (with Regular)</td>
<td></td>
<td></td>
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<tr>
<td>75/25 (with Lispro)</td>
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<tr>
<td>50/50 (with Regular)</td>
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</tbody>
</table>

Insulin Pump Users: Please answer the following:

<table>
<thead>
<tr>
<th>Time</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basal</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

If you take insulin, please answer the following:

- Are you using insulin-to-carbohydrate ratio?  
  - No  
  - Yes  
  - What is the ratio?  
  - _____ Units of insulin per _____ grams of carbohydrates

- Do you supplement with extra insulin when your blood glucose is high (sliding scale)?  
  - No  
  - Yes  
  - Fill in the scale you use in the table:

**Supplemental Scale (correction factor)**

<table>
<thead>
<tr>
<th>Blood Glucose</th>
<th>Plus Insulin</th>
</tr>
</thead>
</table>

- Injection sites  
  - Stomach  
  - Arm  
  - Leg  
  - Buttocks

- Where do you store unopened insulin?  
  -         

- Do you use an insulin pen?  
  - No  
  - Yes  
  - Name:  

Where do you dispose of needles/syringes/lancets?  

**BLOOD GLUCOSE MONITORING:**

- Are you testing your blood glucose (sugar)?  
  - No  
  - Yes  
  - How Often?  

- What time(s) of the day do you test?  
  -         

- Do you have a target blood glucose range?  
  - No  
  - Yes  
  - What is it?  
  - _____ mg/dl to  
  - _____ mg/dl

- Do you know your last A1C?  
  - No  
  - Yes  
  - Result:  
  - Date:  

- Do you ever check your ketones?  
  - No  
  - Yes  
  - When?  

- Do you use foil-wrapped ketone strips?  
  - No  
  - Yes

**HYPOGLYCEMIA:**

- Do you experience low blood glucose (hypoglycemia)?  
  - No  
  - Yes  

- What time of day does it occur?  
  - Do you require assistance?  
  - No  
  - Yes

- Do you have lows that you don’t feel?  
  - No  
  - Yes  

- Do you carry food or other source to treat lows?  
  - No  
  - Yes  

- Do you wear a medical ID?  
  - No  
  - Yes  

- Do you have a glucagon emergency kit?  
  - No  
  - Yes  
  - Expiration date:  

- Humalog (Lispro)  
- Novolog (Aspart)  
- Lantus  
- 70/30 (with Aspart)  
- 70/30 (with Regular)  
- 75/25 (with Lispro)  
- 50/50 (with Regular)
## LIFESTYLE AND BEHAVIORAL ASSESSMENT

### My Diabetes:

**What are your most important concerns in managing diabetes?**

<p>| | |</p>
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</table>

**What would you most like to learn during your visits for diabetes education?**

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### Check the health concerns below that affect you:

- Difficulty sleeping (such as insomnia, sleep apnea, nightmares, talking your sleep)
- Problems with eating or exercising (such as eating too little, avoiding food, overeating, over-exercising)
- Depression or noticeable mood changes (such as feeling sad, having mood swings, irritability)
- Anxiety, nervousness, or stress (such as feeling worried all the time, tense)
- Difficulty in social, school or work environments (such as decreased productivity, avoidance, social isolation, withdrawal)
- Difficulty with relationships with other people (such as friends, people at work)
- Problems within your family (such as conflict, marital conflict, disciplining children)
- Problems with certain kinds of inappropriate or undesirable behavior (such as aggression, anger repeating behaviors you do not want to repeat, illegal behavior)
- Addictive behaviors (such as drug or alcohol abuse, gambling, workaholic behavior)
- Problems with sexual functioning (impotence, loss of desire, avoidance, orgasmic problems)

### Other Concerns Specific to Diabetes

- Difficulty coping with diabetes (e.g. not being able to test your blood glucose or eat when you need to)
- Problems within your family (e.g. difficulty setting limits with family members or getting support)
- Challenges at work (e.g. getting time to take care of diabetes, discrimination due to diabetes)
- Problems in social situations or relationships due to diabetes (e.g. testing or eating in front of others)

**Have you ever been involved in therapy with a counselor or psychologist?**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>No</td>
<td>Yes</td>
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</tbody>
</table>

**For what reason?**

**When?**

**With Whom?**

**What was helpful?**

**What was not helpful?**

### Who completed this form?

<table>
<thead>
<tr>
<th></th>
<th>Relationship to Patient</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Patient Signature**

### FOR HEALTH PROFESSIONAL USE

- Referral made and accepted
- Referral made and refused
- Referral pending

Rev 07/10
Type of birth control: ____________________________________________________________