DIABETES HEALTH ASSESSMENT

General Information (Please fill in the blanks and mark appropriate boxes)
Date: _____ Name: _____ Physician: _____
Spoken Language: ☐ English ☐ Other: _____ Education: ☐ Elementary ☐ High School ☐ College
How do you learn best? ☐ Written ☐ Discussion/Demonstration ☐ Video ☐ All
Occupation: _____ List those living at home with you: _____

Illness History
How long have you had diabetes? _____ Received education? ☐ Yes ☐ No

(Check all that apply):

Condition	Self	Family History	Condition	Self	Family History
Type 1 diabetes			Neuropathy		
Type 2 diabetes			Thyroid problems		
Gestational diabetes			Illicit drug use		
High cholesterol			Difficulty reading		
High triglycerides			Hearing problems		
High blood pressure			Learning disabilities		
Stroke			Depression		
Heart disease			Excessive stress		
Kidney disease			Tobacco use		
Skin problems			Eye Disease: retinopathy, glaucoma, cataracts		
Gastro-intestinal problems					

Please list any other significant medical information/surgeries: _____

_____

Date of last: Dental exam: _____ Foot exam: _____ Eye exam: _____
Do you wear glasses? ☐ Yes ☐ No Do you have any special needs? _____

Social History
Do you exercise? ☐ Yes ☐ No Type: _____ Duration: _____
Do you drink alcohol? ☐ Yes Amount, type _____ ☐ No

Health History for Women
Are you currently pregnant? ☐ Yes ☐ No Are you planning to become pregnant? ☐ Yes ☐ No
Are you aware of the effects of diabetes on pregnancy? ☐ Yes ☐ No
Have you ever had a baby over 9 pounds? ☐ Yes ☐ No
Number of pregnancies: _____ Number of lives births: _____
Problems: _____

Patient Label

Medication List
Please list all medications, including vitamins and herbs.

Name	Time of day taken	How many times a day taken	Reason for taking medication

Allergies: _____
Have you had a flu shot? ☐ Yes ☐ No Have you had a pneumonia shot: ☐ Yes ☐ No

Monitoring
How often do you test: _____ Average readings: _____ Meter: _____

	Yes	NO
Do you have a home blood glucose meter?		
Have you ever had a low blood sugar?		
Have you ever had a high blood sugar?		
Have you ever had to use glucagon?		
Do you wear a medical identification bracelet or necklace?		

Educational Needs
My diabetes has caused problems in the following areas:
☐ Family/social life ☐ Work/School ☐ Sports/Exercise ☐Sexual relations ☐ Travel
☐ Finances*, do you require financial assistance? ☐ Yes ☐ No
☐ Other _____

What is your goal for this education session?
☐ Learn more about diabetes ☐ Help with meal planning ☐ Better blood sugar control
☐ Weight management ☐ Other: _____

Patient Signature: _____

Comments: _____

Patient Label

Current Diet History (Include amounts and how prepared. Also include fluids)

Date:_____

	Breakfast	Lunch	Dinner	Snacks
Day 1				
Day 2				
Day 3				

Notes:_____

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