DuPage Medical Group
WE CARE FOR YOU

Diabetes Mellitus - Assessment Form

You are about to take a big step in controlling your diabetes. Please take a few minutes to fill out this form to help the Diabetes Education Team meet your needs.

PLEASE PRINT If you do not know the answer to any questions, print "don't know."

GENERAL INFORMATION

Today's date: ______________________ Physician Name ____

Name ____ Sex: M F Birth date ________________

Address ____ City, Zip ___________________ SSN ____________

Phone (home) (______) _______________________________ (work) (______) ______________________________

SOCIOECONOMIC BACKGROUND

Circle one in each column

Race	Marital Status	Highest Schooling	Insurance
African American	Single	Less than 8th grade	Public Aid
American Indian	Married	Some high school	HMO
Asian	Widowed	High school graduate	PPO
Caucasian	Divorced	Some college/tech	Medicare
Hispanic	Separated	College graduate	____________________
Other______________			

Circle any problem you have: seeing hearing learning Explain: ____

How do you learn best? Group Class Private Discussion Reading Movies Practicing

I. HEALTH HISTORY

Please check all conditions that you have had and describe your problem the best that you can:

- ☐ Bladder problems
- ☐ Diarrhea/Constipation
- ☐ Eating/appetite problems
- ☐ Problems with walking
- ☐ Overweight
- ☐ Stroke
- ☐ High cholesterol
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Eye problems
- ☐ Numb or painful hands/legs/feet
- ☐ Foot calluses, shoe-fitting problems
- ☐ Dizziness

Please describe your problems checked above as best that you can:

____

____

____

How often do you get examined by an eye specialist doctor (ophthalmologist)? ____________________________

Have you had laser treatment? ____

How often do you examine the condition of your feet? *Choose one:*

______Every day ______time/week ______times/month ______Not often ______Never

Who cuts your toenails? ______________________________ When was the last time you saw a foot doctor? ____________

Describe what you do to prevent foot and skin problems: ____

____

____

II. DIABETES HISTORY and ASSESSMENT

When (date) did you learn you had diabetes? ____________________

Do you have a family history of diabetes? Yes No Who? ____________________

Do you use tobacco? Yes No How often?____________________

Do you drink alcohol? Yes No Indicate number/type of alcoholic beverages per week: ___Wine ___Beer ___Mixed Drink

In the past year how many times were you in the ______hospital or ______emergency room due to diabetes or low blood sugar problems.

How would you rate your understanding of diabetes? *(circle)* Good Fair Poor

In your own words, what is diabetes and what type of diabetes do you have? ____________________

____

____

How does diabetes impact your life? ____________________

____

If this is not a new diagnosis, please continue. If a new diagnosis go to III.

How hard is it for you to care for your diabetes? *(Check the answer that is closest to how you feel)*

______ No problem doing what I need to do to control my diabetes

______ I manage OK about 75% of the time with only minor problems

______ I manage, but it is very difficult many times

______ I do not know if I can do anything to control my diabetes

What is the range of blood sugar levels? Between____________ and ____________

How does having diabetes impact your life? ____________________

____

III. NUTRITION HISTORY

Current height:____________ Current weight:____________ Is this a good weight for you? Yes No

If no, please explain:____________________

What information would you like from our dietitian? *(circle all that apply)*

Weight loss	Eating away from home	Handling food cravings
Meal planning	Reading food labels	Ethnic/Cultural Preference
Low-fat foods	Grocery shopping	Other____________

How many meals do you eat each day? ____________ How many times/day do you eat snacks?____________

Briefly state food choices and times:

Breakfast: ____________________ Time:__________

Lunch:____________________ Time:__________

Dinner: ____________________ Time:__________

Snacks: ____________________ Time:__________

When was the last time you met with a dietitian? ____________________

Who shops for food at home?____________________ Who does the cooking?____________________

How frequently do you eat out in one week?; Which meals? ___B ___L ___D

IV. MEDICATION (If you do not take medicine for diabetes, skip this section)

What medicines do you take for **diabetes**, how much do you take and at what times of the day?

Medication: ______________________ Dose: ______________ Time: ________

Medication: ______________________ Dose: ______________ Time: ________

Medication: ______________________ Dose: ______________ Time: ________

Dietary Supplements, herbs ______________________ Dose: ______________ Time: ________

Have you ever forgotten to take your diabetes medicine? Yes No If yes, what did you do then? ______________________

____

____

V. EXERCISE and ACTIVITY

Do you have a regular exercise plan? Type of activity: ______________________

If you exercise **for at least 20 minutes or more without stopping**, please circle the choice that best describes how often/how long you exercise. (If not, go to next question marked *)

Circle one:	Circle one:	Circle all that apply	Barriers to exercise
6-7 times per week	more than 1 hour	inside bike in place	Time ______________
4-5 times per week	one hour	bike outside	Physical Limitations ______________
2-3 times per week	45 minutes to 1 hour	walk inside	______________
1 time per week	30 to 45 minutes	walk outside	Other ______________
3 times a month or less	20 to 30 minutes	other type of activity	______________

*What else do you do to keep active? ______________________

VI. PREGNANCY

Have you ever been pregnant? ☐ Yes ☐ No

Year							
Birthweight							

Do you or have you had ☐ Type 1 Diabetes Diagnosis Date ______________

☐ Type 2 Diabetes Diagnosis Date ______________

☐ Gestational Diabetes Dates? ________ ________ ________ ________ ________

Have you ever received Post Partum Consultation? ☐ Yes ☐ No

Preconception Consultation? ☐ Yes ☐ No

Consultation from

☐ Physician ______________

☐ Nurse ______________

☐ Other ______________

Reviewed	Date