Patient's Name:_____DOB_____Vision #_____

Diabetes Health Form

To be completed for FIRST VISIT Prior to seen CDE

Your Preferred Name:

Please give an example of a typical meal and snacks

Breakfast (*Time*):_____	**Lunch (*Time*):**_____	**Evening (*Time*):**_____
AM Snack (*Time*):_____	**PM Snack (*Time*):** _____	**Bedtime Snack (*Time*):**_____

How often do you eat your meal at same time each day?

❒75-100% ❒50-75% ❒25-50% ❒0-25%

Living arrangement

❒ Live alone ❒ Live with friends

❒ Live with spouse/children ❒ Live with parents

Who cooks at home?_____

Do you usually skip meals?

❒ No

❒ Yes __Breakfast __Lunch __Dinner(supper)

Reason for skipping_____

What time do you usually

Wake up :_____

Go to sleep: _____

Do you sleep well at night? ❒ Yes ❒ No

Your usual work schedule

❒ Constant ❒ Full time

❒ First shift ❒ Part time

❒ Second shift ❒ Unemployeed/housewife

❒ Night shift ❒ Disabled

❒ Varies:_____ ❒ Retired

How often do you eat out?

❒ 1-2 times a week

❒ 3-4 times a week

❒ 5-7 times a week

❒ Occasional

❒ Rare

Type of setting for eating out

❒ Cafeteria style

❒ Fast food

❒ Buffet

❒ Sit-down restaurant

❒ Others:_____

Type of beverages drink daily and how much?

❒ Water ❒ Others:_____

❒ Unsweetened tea

❒ Diet soda

❒ Coffee

❒ Juice

❒ Milk

Drink alcoholic beverages?

❒ Never

❒ Socially

❒ Less than 1 daily

❒ 1-2 drinks daily

❒ 3 or more daily

What makes it hard for you to eat healthy?

❒ Work or school ❒ Nothing

❒ No family support ❒ I don't know how

❒ Money problems ❒ I am not interested

Issues affecting food intake?

❒None ❒Emotional /stress eating

❒Food cravings ❒Vegetarian

❒Nausea/Vomiting ❒Food allergy

❒Food preparation issues ❒Other_____

Food Personalities

❒ Chocolate/sweets/chips Lover ❒ Always hungry

❒ Grazer (snacking all the time!) ❒ Eats large portion

❒ Carboholic (carb lover) ❒ Never had a problem

❒ Meat and potatoes

❒ Chronic Dieter

❒ Skimp and Binge(skip and eat little during the day, then binge on 1 or 2 meals/snacks because of hunger

Lifestyle Personalities

❒ Restaurant Eater

❒ Work Dictates Diet

❒ Microwaver

❒ Home with the kids (and their Junk food!)

❒ Always Cooking (for everyone else!)

❒ Late-Night Eater

❒ Erratic eating schedule

❒ Late riser

Patient's Name:_____DOB_____Vision #_____

How active are you at home/work during the day?
❒ Sitting most of the time (Very sedentary)
❒ Up and active at work and home (Somewhat sedentary)
❒ Doing projects at home (Moderately active)
❒ Work labor intensive job (Very active)

What do you do for exercise or physical activity?
❒ Nothing
❒ Run
❒ Weight lifting
❒ Brisk walking
❒ Other _____

How regular is your exercise?
❒ Exercise daily
❒ Exercise 4-5 times a week
❒ Exercise 1-3 times a week
❒ Exercise randomly
❒ Exercise rarely
❒ No exercise

What gets in the way of exercising?
❒ Nothing
❒ No time
❒ Pain
❒ Do not know how to exercise
❒ Do not know where to exercise
❒ Do not want to exercise

Do you currently have a glucose meter to monitor your blood sugar?
❒ Yes
❒ No

How often do you monitor your blood glucose level?
❒ Daily
❒ 2-3 times a week
❒ Once a week
❒ Random
❒ Rarely
❒ none

What makes it hard for you to check your blood sugar?
❒ Nothing
❒ Can't remember
❒ Cost of strips
❒ Too many time to test
❒ Don't need too

What are your current blood glucose ranges?
❒ Fasting BG:_____
❒ Pre-meal BG:_____
❒ Post-meal BG:_____
❒ Bedtime BG: _____
Any low BG: ❒ Yes ❒ No

Are you currently taking any diabetes medication?
❒ Yes ❒ No

How often did you <u>miss</u> taking your diabetes medicine?
❒ Never
❒ Rarely
❒ Sometimes
❒ Frequently

What makes it hard for you to take your diabetes medicines?
❒ Nothing
❒ Can't remember
❒ Cost of medicines
❒ Dose is too high
❒ Too many pills and/or injections
❒ Don't want the side effects

How would you rate your current stress level?
❒ Low
❒ Medium
❒ High
❒ Very high

How would you describe your overall emotional state?
❒ Anger
❒ Bored
❒ Depressed
❒ Deprived
❒ Hopeless
❒ Lonely
❒ Tired
❒ Worried
❒ None of those

Patient's Name:_____DOB_____Vision #_____

How long have you had diabetes?
❒ New diagnosis
❒ 1-5 years
❒ 6-10 years
❒ 11-15 years
❒ >15 years

Have you had diabetes education in the past?
❒ No
❒ Yes, When? _____

Rate your knowledge of diabetes.
❒ Good
❒ Fair
❒ Poor

What is most important for you to LEARN about to help you take care of your diabetes?

❒ Healthy eating
❒ Being active
❒ Taking medications as directed
❒ Monitoring my blood glucose
❒ Reducing Risks
❒ Problem-Solving
❒ Healthy Coping
❒ Other:

Do you have any problems learning new things?

❒ No
❒ Yes: __Vision __Hearing _Memory
__Language __Reading is hard
Other:_____

How do you feel about having diabetes?
❒ Accepting
❒ Adjusting
❒ Angry
❒ Denial
❒ Fear
❒ Confused
❒ Sad

What gets in the way of taking care of your diabetes?
❒ Nothing
❒ No family support
❒ Work or school
❒ Money problems
❒ I don't know how
❒ I am not interested

For Women Only: Have you had gestational diabetes?
❒ Yes
❒ No
❒ Not sure

Primary Support Person
❒ Self
❒ Spouse
❒ Family
❒ Significant other
❒ No one
❒ Other

My goal until my next visit is to work on:
❒ Healthy eating
❒ Being active
❒ Taking medications as directed
❒ Monitoring my blood glucose
❒ Reducing Risks
❒ Problem-Solving
❒ Healthy Coping
❒ Other: _____

The steps I will take to work on this goal:

The things that could make it hard for me to achieve this goal:

What I will need to reach my goal: