Scripps Whittier Diabetes Institute

Scripps Whittier Institute Main Line: (858) 626-5672/ FAX 858-626-7111
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PLEASE PLACE PATIENT LABEL HERE OR FILL OUT

Patient Name: _____

MRN: _____

DIABETES HISTORY AND ASSESSMENT FORM

Diabetes History

How many years have you had diabetes? _____ New Diagnosis: ❑Yes

Who in your family has/had diabetes? _____

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

Check if you have any of the following medical conditions:

❑High blood pressure ❑High cholesterol ❑Heart attack ❑Stroke

❑Numbness/tingling in your hands or feet ❑Sexual problems ❑ Depression

❑Kidney problems ❑Stomach problems ❑Cataracts ❑Glaucoma ❑ GDM

❑ Sleep Apnea ❑Please list other medical conditions you have: _____

Check if anyone in your family has or had any of the following conditions:

❑High blood pressure ❑High cholesterol ❑Heart attack ❑Stroke

List all medications you take. Please include vitamins/supplements:

NAME OF MEDICINE	DOSE	TIME TAKEN	NAME OF MEDICINE	DOSE	TIME TAKEN

Are you allergic to any medication? ❑_____ ❑ Food_____

Do you check your blood sugar? ❑Yes ❑No If yes, how often? _____

Name of blood glucose meter: _____Usual results: _____

Last A1c result: _____Date: _____ Do you get low blood sugar? ❑No ❑Yes

If Yes what time/s of day/night? _____

Do you exercise? ❑Yes ❑No If yes, what do you do? _____ How often? _____

If no, list reason or problems that prevent you from exercising: _____

(Turn Over Please To Continue)

DIABETES HISTORY AND ASSESSMENT FORM *(continued)*

PLEASE PLACE PATIENT LABEL HERE OR FILL OUT

Patient Name: _____

MRN: _____

Have you ever had nutritional counseling? ❑Yes ❑No If yes, how long ago? _____
Do you check your feet? ❑Yes ❑No If yes, how often? _____
Do you drink alcohol? ❑Yes ❑No If yes, what kind and how often? _____
Do you smoke? ❑Yes ❑No Comments: _____

Race/Ethnicity ❑African American/Black ❑American Indian/Alaskan Native ❑Caucasian/White ❑Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino ❑Middle Eastern ❑Asian/Chinese/Japanese/Korean/Pacific Islander

Education Level ❑No Formal Education ❑Some High School (7-11) ❑Some College/Tech ❑Elementary (1-6) ❑High School Graduate/GED ❑College Graduate

When was your last flu shot? _____
When was the last time you had your eyes checked? _____
When was the last time you saw a dentist? _____
Have you been in the emergency room or hospital in the last 6 months? ❑Yes ❑No
If yes, why? _____
Are there specific cultural practices that you follow? ❑Yes ❑No
If yes please describe:_____
What are the things that stress you the most in your life? _____
What helps you relieve your stress?_____
Who can you turn to when you need support? ❑Family ❑Friend
Over the past 2 weeks, have you often been bothered by:
Feeling down, depressed, or hopeless? ❑Yes ❑No
Little interest or pleasure in doing things? ❑Yes ❑No
What do you hope to learn from this educational program? _____
Health Goal: A personal health goal of mine is: _____
In order to meet this goal, I will: _____
How many times/minutes per day? _____ Per week? _____

Please list the typical foods and amounts that you eat and drink on a typical day.

Time: Breakfast: _____Drink _____

Time: Lunch: _____ Drink _____

Time: Dinner: _____Drink _____

Snacks: _____Drink _____

Do you follow a special diet? ❑Yes ❑ No Height _____ Weight _____ Desired Weight_____

Would you like to be contacted about upcoming Clinical Trials? ❑Yes ❑No
Comments: _____

ADA (American Diabetes Association Recognition Program) requires us to collect this information so we may better serve our patients

Diabetes Educator Name: _____Date: _____