Sentara

Name:_____

Date of birth: _____

Diabetes Assessment

ASSESS

Diabetes / Health History **Sentara MyChart Activated ☐ Yes ☐ No**

How confident are you filling out medical forms by yourself? ☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all

Race: ☐ White ☐ Black ☐ Native American/Eskimo ☐ Hispanic ☐ Asian/Pacific Island Multiracial: ☐Yes ☐No ☐ Middle Eastern ☐ African ☐ Other: _____

Primary language: _____ Do you need an interpreter? ☐ Yes ☐ No

When were you diagnosed?	Diabetes Type: ☐ Type 1 ☐ Type 2 History of Gestational Diabetes ☐ Yes ☐ No
Family history of Diabetes? ☐ Yes ☐ No	Who?

Do you test your blood sugar? ☐ Yes ☐ No _____Can you afford your testing supplies: ☐ Yes ☐ No

How often do you test? _____ Do you wear a continuous glucose monitor? ☐ Yes (_____)☐ No

Range of readings? _____ Most recent HgbA1c: Date: _____Result: _____

Do you test your urine for ketones? ☐ Yes ☐ No Any episodes of Diabetic Ketoacidosis? ☐ Yes ☐ No

Has your blood sugar been over 300 mg/dL? ☐ Yes ☐ No When/how often? _____

Has your blood sugar been below 70 mg/dL? ☐ Yes ☐ No When/how often? _____

Health Status:

Height: _____ Current Weight: _____ Any recent weight gains or losses? ☐ Yes ☐ No

If yes, how much_____ Goal Weight: _____ Most recent Blood Pressure____/____

Medications: Are you allergic to any medications? ☐ Yes ☐ No List: _____

Do you take any medications (pills/insulin/insulin pump) for diabetes? ☐ Yes ☐ No List: _____

_____

Do you take any other medications, supplements, or herbs? ☐ Yes ☐ No List: _____

_____ _____

Do you have any difficulty affording your medications? ☐ Yes ☐ No Describe: _____

What vaccinations have you received? _____

Medical History

Heart/Vascular Disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Past Surgeries	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	HIV/Blood disorders	☐ Yes ☐ No	List: _____	
History of stroke	☐ Yes ☐ No	Depression/anxiety	☐ Yes ☐ No	_____	
High blood pressure	☐ Yes ☐ No	Eye problems	☐ Yes ☐ No	_____	
Dental/Gum problems	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No	_____	
Cancer	☐ Yes ☐ No	Foot problems	☐ Yes ☐ No	Other Medical History	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Frequent infections	☐ Yes ☐ No	_____	
Skin problems	☐ Yes ☐ No	Slow healing wounds	☐ Yes ☐ No	_____	
Asthma/Sleep Apnea	☐ Yes ☐ No	Chronic pain	☐ Yes ☐ No	_____	
Thyroid	☐ Yes ☐ No	Nerve problems	☐ Yes ☐ No		
Gastrointestinal	☐ Yes ☐ No	Organ Transplant	☐ Yes ☐ No	If so, which one _____	

Women: Sexuality/Reproduction

Date of last period: _____ Current contraception: _____ Plans for pregnancy in the future? ☐ Yes ☐ No

Experiencing any sexual problems (circle): vaginal dryness loss of libido UTI yeast infection emotional none other: _____

Men: Sexuality/Reproduction

Experiencing any sexual problems (circle): prostate issues erectile dysfunction urinary problems emotional none other: _____

Sentara

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Healthcare Utilization

Have you been admitted to the hospital or gone to the emergency room within the past 12 months? ☐ Yes ☐ No

Reason(s): _____

Who is your primary care physician? _____ Do you have an Endocrinologist? ☐ Yes ☐ No _____

Do you see other specialists? ☐ Podiatrist ☐ Cardiologist ☐ Ophthalmologist ☐ Dentist ☐ Other:_____

Referred for evaluation: ☐ Podiatrist ☐ Endocrinologist ☐ Ophthalmologist ☐ Dentist ☐ Other:_____

Frequency of eye/retinal exams: _____ Frequency of dental exams/cleanings: _____

Have you ever had diabetes education? ☐ Yes ☐ No When? _____ Where? _____

Eating Habits

Currently on a specific meal plan? ☐ Yes ☐ No Describe: _____

Food allergies? ☐ Yes ☐ No List: _____

Appetite is: ☐ Good ☐ Fair ☐ Poor Who does your cooking/shopping?: _____

How often do you dine out weekly? _____ Where do you dine out? _____

Number of Meals per day: _____ Do you snack? If so, when _____

Risk Factors

Do you smoke? ☐ Yes ☐ No For how long? _____ Number of packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No Type? _____ Number of drinks per week? _____

Use recreational drugs? ☐ Yes ☐ No Describe: _____

Exercise

Do you exercise regularly? ☐ Yes ☐ No Physical limitations: _____ Type of Exercise: _____

How long per session? _____ How often per week? _____

Support System

☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed Number of people living in household: _____

Primary support person: _____ Any major stressors in your life? _____

Socioeconomic/Education

Currently employed? ☐ Yes ☐ No Occupation: _____ Highest Level of Education: _____

Retired? ☐ Yes ☐ No Previous occupation: _____

Within the past 12 months, were you worried about food running out before you got money to buy more: ☐ Yes ☐ No

Within the past 12 months, the food you bought did not last and you didn't have money to get more: ☐ Yes ☐ No

How do you learn best? ☐ Reading ☐ Listening ☐ Demonstrations ☐ Other _____

Any barriers to learning? ☐ Trouble seeing ☐ Hard time hearing ☐ Cannot read ☐ Difficulty using numbers to manage health ☐ None ☐ Other:

Cultural Factors

Any special dietary needs due to culture/religion? ☐ Yes ☐ No Describe:_____

Any religious/cultural observances that affect lifestyle? ☐ Yes ☐ No Describe: _____

Health Beliefs, Goals and Attitudes

How do you rate your overall health? (Please check) ☐ Excellent ☐Good ☐Fair ☐Poor

What habits would you like to change to improve your health? _____

Are you feeling overwhelmed with managing diabetes? ☐ Yes ☐ No If yes, who have you reached out to for help? _____

What concerns you most about your diabetes? _____What do you hope to learn today?: _____

Diabetes Care and Education Specialist Signature: _____ Date: _____