DCH Diabetes and Nutrition Education Center

Initial Visit Assessment

DT0024

Ht: _____ Wt: _____

Visitor Attending _____ Relationship_____

Ethnic Background: ☐ Black/African American ☐White/Caucasian ☐ Hispanic

☐Native American ☐Middle-eastern ☐Other: _____

Preferred Language: ☐ English ☐Other: _____

How long have you been diagnosed with Diabetes?:_____ What Type?: ☐ Type 1 ☐ Type 2

☐ Other:_____

Has anyone else in your family been diagnosed with diabetes? ☐Y / ☐N

Who? (mother, father, etc.) _____

Previous Diabetes Education: ☐Y / ☐N When:_____ Where:_____

Medical History: Check all that apply

	Hypertension		Heart Disease		Eye Disease		Sexual problems		
	High Cholesterol		Heart Attack		Kidney Disease		Depression		
	Sleep Apnea		Angioplasty		Neuropathy		Cancer		
	Stroke		Cardiac Stents		Dental disease		Thyroid Disease		

Other medical conditions/ surgeries:_____

_____

_____

Tests/procedures in past 12 months: (Check all that apply)

	Dilated eye exam		Urine test		Foot exam		Dental exam		A1c
	Flu shot		Pneumonia shot		Sleep study		Blood pressure		Cholesterol

Emergency Room visit in past 12 months: ☐Y / ☐N Reason:_____

Admitted to Hospital in past 12 months: ☐Y / ☐N Reason:_____

Primary Care Physician visit in past 12 months: ☐Y / ☐N

Tobacco Use: ☐Y / ☐N / ☐Quit (when?)_____

Type:_____ How much/often:_____

Alcohol Use: ☐ Y / ☐N / ☐Quit (when?)_____

Type:_____ How much/often:_____

Exercise: ☐Y / ☐N What type:_____ How much/often:_____

Interested in: ☐Weight loss/ Goal: _____lbs. ☐Weight gain ☐Weight Maintenance

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Medication:

For Diabetes:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How often are doses missed?_____

Why?_____

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Monitoring:

How often do you monitor your blood sugar level: ☐ _____ times per day ☐ _____times per week

☐Occasionally ☐ I do not monitor my blood sugar Blood sugar Range: _____ to _____

Name of meter:_____ How old is your meter?_____

Have you recently had a **low blood sugar level**? ☐Y / ☐N / ☐Unsure

What symptoms did you have? _____

How often do you have a low blood sugar level? _____

What is your usual treatment for a low blood sugar? _____

Have you recently had a **high blood sugar level**? ☐Y / ☐N / ☐Unsure

What symptoms did you have? _____

How often do you have a high blood sugar level?_____

What is your usual treatment for a high blood sugar level? _____

Social/Stress Factors:

Diabetes support person(s):_____

# of household members:_____ Relation to patient:_____

Occupation: _____

Last level of education completed: _____

Do you have any difficulty with: ☐Hearing ☐Seeing ☐Reading ☐ Speaking

Please explain:_____

How do you learn something new the best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing/hands on

Stress level: ☐Low ☐Moderate ☐High. What are the major stressors:_____

_____

What do you do to manage your stress?:_____

Main concern about having diabetes:_____

How do you feel about having diabetes? _____

Are you ready to make lifestyle changes:☐ Y / ☐N / ☐Unsure

What do you believe are barriers to managing your diabetes? (Ex. Finances, time, lack of support)

_____

Do you have any Cultural or religious beliefs that influence how you manage your diabetes? If so, please explain:_____

Meal Planning

Please give a sample of your meals for the past 24 hours (including drinks):

1st meal **Time:_____**	**2nd meal** **Time:_____**	**3rd meal** **Time:_____**
Snack **Time:_____**	**Snack** **Time:_____**	**Snack** **Time:_____**

Who is the grocery shopper at home? ☐Self / ☐Other:_____

Who is the primary cook at home: ☐Self / ☐Other:_____

How often are meals eaten out:_____

Do you read food labels: ☐Yes / ☐No

Which meal time(s) do you typically skip: ☐ Breakfast ☐Lunch ☐Dinner ☐None

List any dietary restrictions:_____

_____