Diabetes Education History Form

Name: _______________________________ Date of Birth: ___________ Today’s Date: ________

Allergies: □ Yes □ None known  If Yes, to what? ____________________________________________

Medical History: Please check any conditions that you have now or had in the past.

☐ No medical conditions  ☐ Diabetes  ☐ Impotence
☐ Arthritis  ☐ Diabetes in Pregnancy  ☐ Kidney disease
☐ Gout  ☐ Headaches  ☐ PCOS
☐ Bowel problem  ☐ Heart Disease  ☐ Skin ulcer
☐ Cancer  ☐ High blood pressure  ☐ Stroke
☐ Cataracts  ☐ Hospitalized for diabetes  ☐ Thyroid issues
☐ Depression  ☐ Other __________________________________________

Surgical History: Please check any conditions that you have now or had in the past.

☐ No surgeries  ☐ Colon surgery  ☐ Kidney transplant
☐ Abdominal surgery  ☐ Eye surgery  ☐ Skin biopsy
☐ Back surgery  ☐ Heart surgery  ☐ Thoracic surgery
☐ Brain surgery  ☐ Hysterectomy  ☐ Vascular surgery
☐ Breast surgery  ☐ Other __________________________________________

Family History: Please check the box if your family member has a history of the following conditions.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Anemia</th>
<th>Cancer</th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>High Blood Pressure</th>
<th>High Cholesterol</th>
<th>Stroke</th>
<th>Thyroid Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paternal Grandfather</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Alcohol Use: □ Yes □ Not currently □ Never
How many drinks per week: Glasses of wine _____ Cans/Bottles of beer _____ Shots of liquor _____

Sexual Activity: Are you sexually active? □ Yes □ Not currently □ Never
If using birth control, is it hormonal? □ Yes □ No □ None
Comments: ____________________________________________________________

Recreational Drug Use: □ Yes □ Not currently □ Never □ Passive smoke exposure
□ Anti-anxiety medications □ Cocaine □ Heroin □ Marijuana □ Methamphetamines
□ Narcotics □ Other ______________________________________________________

Tobacco Use: □ Yes □ Not currently □ Never □ Passive smoke exposure
If Yes: Start date: ______ Quit date: ______ Packs per day? ______ How many years? ______

Smokeless Tobacco: □ Current □ Former user □ Never used □ Passive smoke exposure
□ Check here if your medication record in Epic is up to date

Medications & Nutritional Supplements:
□ Check here if your medication record in Epic is up to date

Pharmacy: ___________________________ Phone number: ___________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Route</th>
<th>How often</th>
<th>Date started</th>
<th>What is it for?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**DIABETES HISTORY**

Why are you coming in for your visit today? ________________________________

What concerns or questions do you have today? ________________________________

**General Information:**

How do you learn best?
- □ Listening
- □ Looking
- □ Reading
- □ Touching/Doing
- □ Talking/Writing
- □ Thinking/Mathematical

Employment status:
- □ Work full time
- □ Work part time
- □ Stay at home
- □ Looking for work
- □ Retired

Education level:
- □ Completed 8th grade or less
- □ High school graduate
- □ Some college
- □ Associate’s degree
- □ Bachelor’s degree
- □ Post-graduate degree
- □ Other ________________________________

Barriers to learning:
- □ None
- □ Financial
- □ Written language
- □ Spoken language
- □ Vision
- □ Emotional/Cognitive
- □ Family support
- □ Hearing
- □ Cultural
- □ English as a Second Language
- □ Reading/Numbers
- □ Physical
- □ Use of technology
- □ Other ________________________________

What topics would you like to learn about today?
- □ Healthy eating
- □ Physical activity
- □ Blood glucose monitoring
- □ Low blood glucose treatment
- □ High blood glucose treatment
- □ Long term complications
- □ Coping skills
- □ Diabetes medicines
- □ New technology
- □ Other ________________________________

**Relevant Diabetes History:**

How long have you had diabetes?
- □ Less than 2 years
- □ 2-5 years
- □ 6-10 years
- □ More than 10 years

When did you last have diabetes education?
- □ Never
- □ Less than 2 years
- □ 2-5 years
- □ 6-10 years
- □ More than 10 years ago

How would you rate your present health status?
- □ Excellent
- □ Good
- □ Fair
- □ Poor

Any recent changes in your weight?
- □ Recent weight loss
- □ Recent weight gain
- □ No recent weight change

How much? ___________ What is your current weight? ___________ How tall are you? ___________

Have you ever been hospitalized due to diabetes?
- □ In the past year
- □ More than 1 year ago
- □ Never hospitalized for diabetes
Current diabetes symptoms:
☐ None ☐ Excessive thirst ☐ Frequent urination ☐ Unexplained weight loss ☐ Fatigue
☐ Numbness in hands or feet ☐ Blurred vision ☐ Other ______________________________

Blood Glucose Monitoring:
Are you monitoring your blood glucose?  ☐ Yes ☐ No  If Yes, what meter do you use?_________
How frequently do you test? ___________ What are your target blood glucose levels?_________

Low or High Blood Glucose:
Have you had a low blood glucose in the last month?  ☐ Yes ☐ No
Can you recognize the symptoms of a low blood glucose?  ☐ Yes ☐ No
Comments ____________________________________________________________

How do you treat a low blood glucose?
☐ Glucose tabs ☐ Regular juice or soda ☐ Sugar ☐ Candy ☐ Other____________________

What are your symptoms of high blood glucose? ______________________________________
How do you treat a high blood glucose?
☐ Water ☐ Broth ☐ Exercise ☐ Diabetes medication ☐ Call my provider ☐ Do nothing

Distress Level:
Listed below are problems that people with diabetes may experience. Consider the degree to which each of these may have distressed or bothered you during the past month and circle the answer that best describes how you feel:
1. Feeling overwhelmed by the new diagnosis or demands of living with diabetes?
   Very ☐ Somewhat ☐ Not at all
2. How important to you is making changes to improving your diabetes care?
   Very ☐ Somewhat ☐ Not at all
3. How confident are you in your ability to learn about diabetes and make changes to improve your health?
   Very ☐ Somewhat ☐ Not at all
4. How satisfied are you with how you are managing your diabetes?
   Very ☐ Somewhat ☐ Not at all

What gets in the way of managing your diabetes?
☐ Stress ☐ Work ☐ Family ☐ Friends ☐ Emotions ☐ Money ☐ Health problems
☐ Lack of time ☐ Lack of knowledge ☐ Nothing ☐ Other ______________________________

Who helps you with your diabetes?
☐ Family ☐ Co-workers ☐ Friends ☐ Health care provider ☐ Support group
☐ No one ☐ Other ______________________________
What methods do you use to manage stress? (Please check all that apply)

☐ Avoid stimulants  ☐ Relaxation techniques  ☐ Physical activity  ☐ Talking to someone
☐ Proper sleep  ☐ Learn to say “no”  ☐ Keeping a journal  ☐ Set realistic expectations
☐ Manage time  ☐ Other ________________________________

Meal Planning:
Do you have a meal plan for diabetes management?  ☐ Yes  ☐ No  If Yes, what is it?
___________________________________________________________

How well does this meal plan work for you?  ☐ Very well  ☐ Somewhat  ☐ Not at all  ☐ Not applicable

Activity:
Do you exercise regularly?  ☐ Yes  ☐ No  If yes, what type of exercise?

☐ Walk  ☐ Weights  ☐ Gym  ☐ Run  ☐ Stretches
☐ Stair Stepper  ☐ Swim  ☐ Yoga  ☐ Bike  ☐ Aerobics/dance
☐ Other ________________________________

How many times per week do you exercise? ________________________________
How many minutes do you exercise?  ☐ Less than 15  ☐ 15-30  ☐ 31-45  ☐ 46-60  ☐ More than 60

Preventive Health:
When did you last have a dilated retinal exam?  ☐ Within the 1 year  ☐ More than 1 year ago  ☐ Never
When did you last see the dentist?  ☐ Past 6 months  ☐ Past 6-12 months  ☐ More than 1 year ago
Do you check your feet daily?  ☐ Yes  ☐ No
When did you last have a flu shot? ________________________________
When did you last have a pneumonia vaccine? ________________________________

Thank you!