NAME: **DOB** Date: ___/___/_____

Phone (Preferred): ( ) - Home ☐ Work ☐ Cell ☐

AIC: Date: ___/___/_____ Blood sugar range:_____ to _____

What is your language preference: English ☐ French ☐ Spanish ☐ Other ☐ _____
Ethnic Background: White/Caucasian ☐ Black/A-A ☐ Hispanic ☐ Native American ☐ Middle-eastern ☐

1. What type of diabetes do you have? Type 1☐ Type 2☐ Pre-diabetes☐ GDM☐ Don't Know☐

2. Year/Age of Diabetes Diagnoses: ____ / ___
List relatives with diabetes: Father ☐ Mother ☐ Sibling ☐ Other ☐ _____

3. Have you had previous instruction on how to take care of your diabetes? Y☐ N☐ How long ago: _____

4. How do you learn best: listening☐ reading☐ observing☐ doing☐
What is the last grade of school you have completed? _____

5. Do you have any difficulty with: Hearing☐ Seeing☐ Reading☐ Speaking☐
Explain any checked: _____

6. Are you currently employed? Y☐ N☐ What is your occupation? _____ Hours: _____

7. Marital Status: Single☐ Married☐ Divorced☐ Widowed☐

8. How many people live in your household? ___
How are they related to you? _____

9. From whom do you get support for your diabetes?
Family ☐ Co-workers ☐ Healthcare providers ☐ Support group ☐ No-one ☐

10. Check any of the following tests/procedures you have had in the last 12 months:

dilated eye exam ---------- ☐	dental exam ---------- ☐	HgA1c ---------- ☐
urine test for protein ---------- ☐	blood pressure ---------- ☐	flu shot ---------- ☐
foot exam-self ---------- ☐	weight ---------- ☐	pneumonia shot ------- ☐
Foot exam-health professional --- ☐	cholesterol ---------- ☐	Shingles vaccination ☐

11. In the last 12 months, have you: used emergency room services☐ been admitted to a hospital☐
Was ER visit or hospital admission diabetes related? Y☐ N☐

12. Do you have any of the following:

eye problems ---------- ☐	apnea, sleep ---------- ☐
kidney problems ---------- ☐	high blood pressure ------- ☐
numbness/tingling/loss of feeling in your feet ---- ☐	high cholesterol ---------- ☐
dental problems ---------- ☐	sexual problems ---------- ☐
	Depression ---------- ☐

Any other health problems?_____

13. Please list all medications (Use back if more room needed or see attached medication sheet): _____

About how often do you miss taking your medication as prescribed? Never ☐ Other ☐ _____

NAME:_____
DOB_____ **OR**
PLACE LABEL HERE

14. Height: _____ Weight: _____
Do you have a meal plan for diabetes? ---------- Y☐ N☐
If yes, please describe: _____
About how often do you use this meal plan? ---------- Never☐ Seldom☐ Sometimes☐ Usually☐ Always☐
Do you read and use food labels as a dietary guide? --- Y☐ N☐
Do you have any diet restrictions: ---------- Salt☐ Fat☐ Fluid☐ None☐ Other☐
If Other, please describe: _____

Give a sample of your meals for a typical day:

Time: _____ Breakfast	Time: _____ Lunch	Time: _____ Supper
Food: _____	Food: _____	Food: _____
Drink:	Drink:	Drink:

Time: _____ Snack 1	Time: _____ Snack 2	Time: _____ Snack 3
Food: _____	Food: _____	Food: _____

15. Do you: Do your own food shopping? Y☐ N☐ Cook your own meals? Y☐ N☐
How often do you eat out?_____ Drink Soda/Sweetened Beverages? Y☐ N☐

16. Do you drink alcohol? Y☐ N☐ Type:_____ How many? _____ per day☐ per week☐ occasionally☐
Do you use recreational drugs Y☐ N☐

17. Do you use tobacco: cigarette☐ pipe☐ cigar☐ chew☐ none☐ quit☐ how long ago _____ how much_____

18. Do you exercise regularly? Y☐ N☐
Do you have any problems with exercise? _____
My exercise routine is: easy ☐ moderately intense ☐ very intense ☐

19. Do you check your blood sugars? Y☐ N☐
How often? _____ When? _____
What is your target blood sugar range? _____ What type of meter do you use? _____

20. In the last month, how often have you had a low blood sugar reaction? _____
Can you tell when your bloods sugar is low and describe? _____
How do you treat your low blood sugar?_____

21. Can you tell when your blood sugar is too high? Y☐ N☐ What do you consider High? _____
What do you do when your sugar is high?_____
In the last month how often were you over 240 for type 2 or 300 for type 1? _____

22. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?
Y☐ N☐ Please describe _____

23. Do you use technology to look for health and other information Y☐ N☐
Would you like to give us your e-mail for future mailings: _____

24. What concerns you most about your diabetes? _____

25. What is hardest for you in caring for your diabetes? _____

NAME:_____
DOB_____ **OR**
PLACE LABEL HERE

26. Do you wear identification that you have diabetes? _____

27. Pregnancy and Fertility:
Are you: Pre-menopausal ☐ Menopausal ☐ Post-Menopausal ☐ N/A ☐
Did you ever have gestational diabetes? Y☐ N☐ When: _____
Are you pregnant? Y☐ When are you expecting? _____ NO ☐ Are you planning a pregnancy? _____
Have you been pregnant before? Y☐ N☐ Weight of Baby: _____
Are you aware of the impact of diabetes on pregnancy? Y☐ N☐
Are you using birth control? Y☐ N☐ If "Yes", please specify: _____

28. How do you handle stress? _____

29. In your own words, what is diabetes? _____

Your Education Goals: What do you want to learn? Check all that apply

Meal Planning and Eating Out?	☐	Complications of Diabetes?	☐
What is Diabetes?	☐	How to Cope with a Chronic Illness?	☐
Physical Activity Concerns	☐	What I need to do to Manage my Db?	☐
How to take my Medications?	☐	What is New in Diabetes?	☐
How to check my blood sugar?	☐	Other?	☐

Your Signature: _____

Please do not write below this line

CLINICIAN ASSESSMENT SUMMARY: _____

Education Needs/Education Plan:

Nutritional Management	☐	Preventing Acute Complications	☐
Diabetes disease process	☐	Preventing Chronic Complications	☐
Physical Activity	☐	Behavior Change Strategies	☐
Using Medications	☐	Risk Reduction Strategies	☐
Monitoring	☐	Psychosocial adjustment	☐

Date: ___/___/_____ **Time:** ___:___ Clinician Signature: _____
Date: ___/___/_____ **Time:** ___:___ Clinician Signature: _____

Developed 4-2013, Revised 12-3-14

NAME:_____
DOB_____ **OR**
PLACE LABEL HERE