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| Name: Name you prefer to be called: DOB: Date:  |
| **Lifestyle/Coping and Health Literacy \***Status: Single Married Divorced Widowed – Who else in household? **\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_** Do you work? Yes No Type of work and schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_ Please list cultural or religious beliefs that may impact your care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How do you learn best? Written materials Verbal Discussion Video \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have any difficulty with? (Circle all that apply) Listening - Reading – Writing - Hearing - Seeing Understanding \*Do you need help understanding instructions, pamphlets, or other written material from your doctor or pharmacy? No – Sometimes - AlwaysWhat is your sleep schedule, any problems sleeping? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CPAP used: Yes NoIf you have pain, how does it affect your lifestyle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tobacco Use No Yes Type/Amount/Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Alcohol Use No Type/Amount/Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List any surgeries you have planned in next 3 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason for being in/at hospital, ER, Urgent Care in last 30 days: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Diabetes Distress Support**How would you rate your overall health? o Excellent o Good o Fair o PoorWho else in your family has diabetes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List anything about Diabetes that causes you Stress or Distress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How do you deal with this stress/distress? Primary Support Person: |
| **Being Active/Physical Activity**What physical activity to you do regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What if any barriers do you have to physical activity?  |
| **Clinical History** | ***Educator Completes This Section*** |
| **Yes No** |  | **Diabetes Pathophysiology and Treatment** |
| o o | Eye Problems: | Diabetes type: When diagnosed? |
| o o | Nerve Problems: | Ht.: Wt.: Last A1C (date/Value): |
| o o | Kidney Problems: | Labs (Date: ): Chol.:\_ HDL:\_\_\_\_\_\_\_\_ LDL: \_\_\_\_\_\_\_\_\_ Triglycerides: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ GFR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| o o | Stomach or Bowel Problems: |
| o o | Foot: | If previous diabetes education when/where: |
| o o | Impotence: |
| o o | Frequent Infections: | What are your goals for the education session? |
| o o | Heart Problems: |
| o o | Lung Breathing Problems: | **Monitoring Glucose and Health Literacy\*** |
| o o | High/Low Blood Pressure: | SMBG Times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BG/CGM type: |
| o o | Stroke: when notes: |
| o o | Arthritis notes | BG History: Breakfast: to Lunch to Dinner to HS to  |
| **Chronic Complications: Preventing Detecting Treatment** |
| o o | Do you have a primary care doctor? Last Visit date? | What are bg targets\*? |
| o o | Did MD exam feet? | If using CGM what is your TIR target\*? |
| o o | Do you exam your feet daily? | What is your A1C target\*? |
| o o | Do you see a Podiatrist? Last visit date: | **Taking Medications and Health Literacy\*** |
| o o | Do you see a dentist? Last visit date: | DM oral medications/dose\*/can it cause low bgs\*? |
| o o | Do you see ab eye doctor? Last visit date: |
| o o | Did you get the flu vaccine? Last date: | Insulin/DM Injectables: Type/when/dose\*/sliding scale\*/sites/storage/can it cause low bgs\*? (If insulin: Pens, Vials, Pump)In a typical week how many times do you miss taking your diabetes medicine? |
| o o | Did you get the shingles vaccines? Which one: |
| o o | Did you get the COVID 19 vaccine? Which: |
| o o | Are you pregnant? If so, when are you due?  |
| o o | Are you planning to get pregnant? |
| List any pregnancy complications: |
| **Acute Complications: Preventing Detecting Treatment** | **Healthy Eating and Health Literacy\*** |
| o o | Do you wear a medical ID? | Diet Current and in past: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Knows which foods raise bg\*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Can read food labels\*? oYes oNoFood allergies/ GI issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who shops/cooks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Meals eaten: o Breakfast o Lunch oDinner o SnacksFood Beverage Snack Notes: |
| o o | Hyperglycemia (350 or more)? How often: |
| How do you treat hyperglycemia? |
| o o | Have you ever had DKA? When? |
| o o | Do you ever test for ketones? |
| What would you do if you have ketones? |
| o o | Do you have hypoglycemia? How often? |
| o o | Can you tell when you have hypoglycemia? | **o Needs referral to RD for MNT** |
| How do you manage your diabetes when you are sick? | **Educators Signature/Date** |
| **Other Medications:** *List or attach* |
| How are you prepared with diabetes medications and supplies in case you had to leave your home with little notice and uncertainty of how long? |