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 - Always

What is your sleep schedule, any problems sleeping? _____ _____CPAP used: ☐Yes ☐No

If 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? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who 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**
☐	☐ Eye Problems:	Diabetes type: When diagnosed?
☐	☐ Nerve Problems:	Ht.: Wt.: Last A1C (date/Value):
☐	☐ Kidney Problems:	Labs (Date:_____): Chol.:_____HDL:_____ LDL: _____
☐	☐ Stomach or Bowel Problems:	Triglycerides: _____ GFR: _____
☐	☐ Foot:	If previous diabetes education when/where:
☐	☐ Impotence:	
☐	☐ Frequent Infections:	What are your goals for the education session?
☐	☐ Heart Problems:	
☐	☐ Lung Breathing Problems:	**Monitoring Glucose and Health Literacy***
☐	☐ High/Low Blood Pressure:	SMBG Times? _____
☐	☐ Stroke: when notes:	BG/CGM type:
☐	☐ Arthritis notes	BG History: Breakfast: to Lunch to
Chronic Complications: Preventing Detecting Treatment		Dinner to HS to
☐	☐ Do you have a primary care doctor? Last Visit date?	What are bg targets*?
☐	☐ Did MD exam feet?	If using CGM what is your TIR target*?
☐	☐ Do you exam your feet daily?	What is your A1C target*?
☐	☐ Do you see a Podiatrist? Last visit date:	**Taking Medications and Health Literacy***
☐	☐ Do you see a dentist? Last visit date:	DM oral medications/dose*/can it cause low bgs*?
☐	☐ Do you see ab eye doctor? Last visit date:	
☐	☐ 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)
☐	☐ Did you get the shingles vaccines? Which one:	
☐	☐ Did you get the COVID 19 vaccine? Which:	
☐	☐ Are you pregnant? If so, when are you due?	
☐	☐ Are you planning to get pregnant?	In a typical week how many times do you miss taking your diabetes medicine?
List any pregnancy complications:		
Acute Complications: Preventing Detecting Treatment		**Healthy Eating and Health Literacy***
☐	☐ Do you wear a medical ID?	Diet Current and in past: _____
☐	☐ Hyperglycemia (350 or more)? How often:	_____
How do you treat hyperglycemia?		Knows which foods raise bg*? _____
☐	☐ Have you ever had DKA? When?	Can read food labels*? ☐Yes ☐No
☐	☐ Do you ever test for ketones?	Food allergies/ GI issues: _____
What would you do if you have ketones?		Who shops/cooks: _____
☐	☐ Do you have hypoglycemia? How often?	Meals eaten: ☐ Breakfast ☐ Lunch ☐Dinner ☐ Snacks
		Food Beverage Snack Notes:
☐	☐ Can you tell when you have hypoglycemia?	☐ **Needs referral to RD for MNT**
How do you manage your diabetes when you are sick?		**Educators Signature/Date**
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?		**Other Medications:** *List or attach*