JUPITER MEDICAL CENTER

DIABETES EDUCATION INTAKE ASSESSMENT

Name: _____ Date: _____
Date of Birth: _____Height _____ Weight _____ Goal Weight _____

DIABETES HISTORY

What type of Diabetes do you have? Type 1 ☐ Type 2 ☐ Pre Diabetes ☐ Gestational ☐ I do not know ☐
Year/Age of Diabetes Onset _____
Ethnic Background: Am Indian/Alaskan Native ☐ Black/African Am ☐ White/Caucasian ☐
Asian/Japanese/Chinese/Korean/Pacific Islander ☐ Hispanic/Cuban/Chicano/Mexican/Puerto Rican ☐
Middle Eastern ☐

WOMEN OF CHILD BEARING AGE:
Are you pregnant? No ☐ Yes ☐ If yes, when are you due? _____
Are you planning a pregnancy? No ☐ Yes ☐ When?_____
Are you aware of the impact of diabetes on pregnancy? No ☐ Yes ☐ Are you using birth control ? Yes ☐ No ☐

FOR GESTATIONAL DIABETICS ONLY:
Pregnancy History: # of Pregnancies _____ # Live Births _____ Pre-pregnant weight _____
Previous complications related to pregnancies: _____

DIABETES EDUCATION NEEDS

Do you have a support person (s)? Yes ☐ No ☐ Support person(s) name/relationship _____
Do you know how to manage your diabetes while sick? Yes ☐ No ☐
I have a Diabetes ID with me or available? Yes ☐ No ☐
Describe your current feelings about having diabetes: Sad ☐ Angry ☐ Worried ☐ Burdened ☐ Frustrated ☐
Accepting ☐ Distressed ☐ Frightened ☐ Discouraged ☐ No feelings ☐ Other _____
My memory is: Good ☐ Fair ☐ Poor ☐
How do you learn best: Listening ☐ Reading ☐ Observing ☐ Doing ☐ On Computer ☐ Other _____
Which describes how you feel about learning: Excited ☐ Ready to start ☐ Thinking about it ☐ Not ready ☐
Previous Diabetes Education? No ☐ Yes ☐ Details about education _____
Need Assistance with: Visual Impairment ☐ Hearing ☐ Reading ☐ Physical Limitation _____
What language do you speak/write most often? _____
Financial Difficulties ? Food ☐ Medications ☐ Testing/monitoring supplies ☐ Transportation ☐
Do you have any cultural/religious practices or beliefs that influence how you care for your diabetes? No ☐ Yes ☐
Please explain _____
Hospital stay within the last year? No ☐ Yes ☐ Give details of hospitalization _____
Number of ER visits or 911 calls within the last 3 months? _____

DIABETES TREATMENT OVERVIEW

Current Treatment: None ☐ Diet only ☐ Oral agents ☐ Insulin pen ☐ Insulin vial ☐ Insulin Pump ☐
CGM with pump ☐ Other type of injection please list: _____
Describe how you take your medication: Take as prescribed ☐ Rarely miss a dose ☐ Miss a lot of doses ☐
What do you do if you miss a dose? _____

IF YOU TAKE INSULIN

Where do you store it? _____ How do you dispose of it? _____
What areas of body do you use for injection? _____ Who gives the injection? _____
Do you use a sliding scale? No ☐ Yes ☐ Do you reuse syringes? No ☐ Yes ☐

GLUCOSE MONITORING

Do you check your blood sugars? No ☐ Yes ☐
How often do you check? Once daily ☐ Twice daily ☐ Three times daily ☐ Four times daily ☐ Other _____
When: Before Breakfast ☐ 2 hours after meals ☐ Before Bedtime ☐ Other _____
Results: before meal _____ after meal _____ bedtime _____
Do you keep a record? No ☐ Yes ☐
Have you had a **low blood sugar** in the last 3 months? No ☐ Yes ☐ How often? _____
What time of day _____ At what number? _____ Symptoms _____ Treatment _____
Do you have a glucagon kit? No ☐ Yes ☐ If you have used it, when was last time? _____
Have you had **a high blood sugar** in the last 3 months? No ☐ Yes ☐ How often? _____
What time of day _____ At what number? _____ Symptoms _____ Treatment _____
Do you test for ketones? No ☐ Yes ☐

EYE, FOOT, DENTAL ASSESSMENTS

Yearly dilated eye exam? No ☐ Yes ☐ Date of last exam? _____ Blurry or difficulty seeing? No ☐ Yes ☐
Glasses /contact lenses? No ☐ Yes ☐
Yearly Dental Exam? No ☐ Yes ☐ Date of last exam? _____ Dental problems No ☐ Yes ☐ _____
Yearly Foot Exam? No ☐ Yes ☐ Date of last exam? _____ Numbness/tingling/loss of feeling in feet No ☐ Yes ☐
Barriers to caring for feet? _____

EXERCISE

Do you exercise regularly? No ☐ Yes ☐ Type of exercise? _____ How often? _____
Intensity of my work out is: Light ☐ Moderate ☐ Intense ☐ Barriers to exercising? _____

MEDICAL CONDITIONS/PROBLEMS

Please check all that apply:
Eye problems ☐ Kidney disease ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ High Triglycericles ☐
Anxiety ☐ Depression ☐ Sexual problems ☐
Allergies? No ☐ Yes ☐ Please list _____

SOCIAL HISTORY

Do you Smoke: No ☐ Yes ☐ # years _____ # packs of cigarettes _____
Do you drink alcohol? No ☐ Yes ☐ Type & amount of alcohol? _____ How many drinks/week? _____
Do you drink caffeine? No ☐ Yes ☐ How many cups/day? _____
Vitamin Supplements? No ☐ Yes ☐
Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other's name: _____
Do you feel safe at home? Yes ☐ No ☐ _____
Currently employed? Employed ☐ Part time ☐ Retired ☐ Unemployed ☐ Student ☐ Occupation _____
Highest Grade completed? _____
Do you have any family members with Diabetes? No ☐ Yes ☐ _____

For Office Use Only:
Numeracy and Health Literacy Comments: _____

NUTRITION ASSESSMENT

Do you have a meal plan for diabetes? No ☐ Yes ☐ If yes, describe _____
Do you have diet restrictions? No ☐ Yes ☐ If yes: Salt ☐ Fat ☐ Other _____
Do you eat out? No ☐ Yes ☐ If yes, # times/week ? _____ Type of restaurant? _____
# of members in the household? _____ Please list: _____
Who does the shopping? _____ Who does the cooking? _____
How is your food prepared? Fried ☐ Baked ☐ Broiled ☐ Grilled ☐ Gravy /Sauces ☐
My portions are: Small ☐ Average ☐ Large ☐
I eat Slow ☐ Average ☐ Fast ☐ # of minutes to finish a meal _____
Hunger symptoms? _____
My mood/stress increases my eating ☐ decreases my eating ☐ does not affect my eating ☐
Meals consumed per day: _____ Snacks per day? _____ What kind? _____
I eat desserts: # of times/week _____ or # of times/month _____
I skip meals: No ☐ Yes ☐ Which meal do you skip? _____

Give a sample of your meals for a typical day: Indicate portion sizes!

Time: _____ Breakfast _____

_____

Time: _____ Lunch _____

_____

Time: _____ Dinner: _____

_____

Time: _____ Snacks _____

Time: _____ Snacks: _____

Time: _____ Snacks: _____

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Patient Name: _____ Date: _____

Medication Allergies: _____

Not Taking Any Medications ☐

MEDICATION LIST

LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS			
Name of Medication	**Dose**	**How is it taken? Pill or injection**	**How often is it taken**

JUPITER MEDICAL CENTER

Diabetes Self Management Program

☒ PRE EVALUATION

☐ POST EVALUATION

NAME:_____ DATE_____

1. Diabetes Mellitus is a condition that occurs when:

   A. your body is unable to use the glucose (sugar) from the food that you eat.
   B. your pancreas makes some insulin however, it has difficulty attaching to the cells (Type 2).
   C. you have high blood glucose in your blood stream.
   D. your pancreas does not produce any insulin (Type 1).
   E. all of the above

2. Which of the following is correct regarding diabetes medications that are taken orally:

   A. insulin does not come in "pill" form.
   B. used in addition to your meal plan and exercise in Type 2 diabetes to improved blood glucose control.
   C. side effects can vary from each type of medication.
   D. all of the above

3. When determining how a particular food will effect your blood glucose, the most important aspect to consider is

   A. sugar content
   B. protein content
   C. carbohydrate content
   D. pre-meal blood glucose value

4. What is the "target goal range" that your blood glucose levels need to be before meals?

   A. 30 - 70 mg
   B. 80 - 120 mg
   C. 150 - 200 mg

5. It is best to have ____ hours between meals

   A. 2- 3
   B. 4- 5
   C. 6- 7

6. How does exercise effect your blood glucose level?

A. makes your blood glucose higher
B. makes your blood glucose lower
C. does not effect your blood glucose

7. Family members, community support groups, congregations, and local clubs are all examples of resources to help you medically, psychologically, and spiritually manage your diabetes.

CIRCLE ONE

TRUE FALSE

8. Which would be the most appropriate snack for a person with diabetes?

A. 1/2 peanut butter sandwich
B. granola bar
C. no sugar added frozen yogurt
D. chicken rice soup with croutons

9. If my pre-lunch blood glucoses are consistently over 180 mg, I need to:

A. skip breakfast.
B. exercise after breakfast.
C. make sure I include a protein source with breakfast.
D. decrease my medication.
E. B & C only

10. It is 1:30 pm. You are at the mall and have not eaten since breakfast. You have a headache and feel shaky. You should . . .

A. ignore your headache because you'll only be at the mall another hour
B. rest until the symptoms disappear.
C. test your blood glucose if you have your meter with you.
D. find the nearest soda machine or take glucose tablets.
E. Both C and D.

11. What is the "target goal range" that your blood glucose levels need to be 2 hours after meals?

A. less than 80 mg, up to 120 mg acceptable
B. less than 140 mg, up to 180 mg acceptable.
C. less than 200 mg, up to 250 mg acceptable

12. The Hb A1C (hemoglobin A1C) test reveals your diabetes control over the past ...

A. day.
B. 2 weeks.
C. 3 months.
D. 6 months.
E. 12 months.

13. Which of the following is true?

A. Hb A1C test reveals your diabetes control over the past 3 months and is usually performed every 3-6 months.
B. blood pressure should be monitored at every healthcare visit; normal value for people with diabetes is 130/80 mmHg.
C. cholesterol should be tested at least once a year, desirable value is less than 200mg/dL.
D. all of the above

Diabetes Education Pre Program Questionnaire

To assist us in planning your education we need your input. Please check the topic/ topics you are most interested in learning during your diabetes education sessions. You may choose more than one or all of them.

☐ **Diabetes:** Definition, Types of Diabetes, Signs and Symptoms

☐ **Nutrition Management:** Effect of carbohydrate, protein and fat consumption on blood sugar; Planning Meals; Reading food Labels; Eating Out

☐ **Incorporating physical Activity into Lifestyle:** Benefits of exercise; how exercise changes blood sugar, exercise guidelines and when to exercise

☐ **Medications**: oral medication, insulin and other injectable medications to decrease blood sugar

☐ **Blood glucose monitoring:** selecting a meter, proper technique for testing, desirable blood glucose range, interpreting the results

☐ **Prevention, detection and treatment of complications:** low blood sugars, high blood sugars, other complications

☐ **Develop strategies for living with diabetes:** support needed and available resources to help in managing diabetes

☐ **How to stay healthy with diabetes:** importance of knowing A1C, blood pressure, cholesterol and important health screenings.

Patient Signature: _____ **Date:** _____