CAMPBELL COUNTY HEALTH
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DIABETES CENTER
DIABETES ASSESSMENT

Name:_____ DOB:_____ Date:_____

Learning Styles

How do you learn the best? (Circle all that apply)

Listening Reading Observing Doing

Do you have any trouble with: (Circle all that apply)

Hearing Seeing Reading Speaking

Please describe any specific educational needs:

_____

_____

Diabetes Knowledge

Have you had previous diabetes education? YES or NO

If yes, when and where:

_____

_____

When were you diagnosed with diabetes?_____

Family History

Diabetes: Yes or No Thyroid disease: Yes or No Heart disease: Yes or No

Personal Medical History

Have you ever been diagnosed with any of the following conditions, or do you have a concern? (Check all that apply)

Diagnosed	Concerned		Diagnosed	Concerned	
☐	☐	High Blood Pressure	☐	☐	Heart Disease
☐	☐	Heart Disease	☐	☐	Circulation Problems
☐	☐	Abnormal blood lipids (fats)	☐	☐	Foot Problems
☐	☐	Eye or Vision Problems	☐	☐	Thyroid Disease

☐	☐	Kidney Disease	☐	☐	Liver Disease
☐	☐	Skin Problems	☐	☐	Depression
☐	☐	Dental/mouth Problems	☐	☐	Stomach/Bowel Issues
☐	☐	Sexual dysfunction			
☐	☐	Numbness/tingling/pain (hands, legs, feet)			

In the past 12 months, have you been a patient in the ER? Yes or No

If yes, what for:

_____

_____

In the past 12 months, have you been hospitalized? Yes or No

If yes, what for:

_____

_____

How many visits have you had to your primary care provider in the las 12 months?_____

List any specialists and number of visits you have had with them over the past 12 months?

_____

_____

Date of last eye exam:_____

Do you have a history of:

Vision loss Cataracts Macular Degeneration Glaucoma Laser treatment Eye injections

Date of last dental exam:_____

Do you have a history of periodontal (gum) disease? Yes or No

Date of last foot exam by a healthcare professional: _____

Do you examine your feet? Yes or No

If yes, how often:_____

Do you have a history of: (Circle all that apply)

Numbness Tingling Pain Toenail problems Foot infections Amputations

Is there protein in your urine: Yes No Unknown

Date of last flu vaccination:_____ Date of last Pneumonia vaccination:_____

Pregnancy and Women Fertility Only

Are you of child bearing ages? Yes or No

Are you currently pregnant? Yes or No

Are you considering pregnancy? Yes or No

Have you been pregnant before? Yes or No

If yes, did you have gestational diabetes? Yes or No

If yes, did your baby weigh over 9 lbs? Yes or No

Are you currently using birth control? Yes or No

Are your menstrual cycles regular? Yes or No

If no, please explain:

_____

_____

Exercise

Do you exercise? Yes or No

If yes, what type of exercise:_____

How many times a per week do you exercise?_____

For how many minutes per time?_____

Have you been advised by a physician to limit your exercise in any way? Yes or No

If yes, please explain:

_____

_____

Weight

Has your weight changed over the past year? Yes or No

If yes, please explain:

_____

_____

Nutrition

What food-planning methods have you followed in the past? (Circle all that apply)

Calorie counting Carbohydrate counting Low carbohydrate Exchange list Low fat

No added sugar Food Pyramid Healthy choices My plate Other:_____

What method are you currently using?_____

How many meals per day do you eat?_____

How often do you eat out in a week?_____

Who does the meal planning, grocery shopping, and cooking in the household?_____

Do you have any dietary restrictions?_____

What is your typical daily schedule/meals/snacks:

	Time	Typical Meals/Snacks
I get up at		
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Evening Meal		
Bedtime Snack		
I go to bed at		

Medications

What type of diabetes medications are you currently taking? (Circle all that apply)

Oral Non-Insulin Injectable Insulin Not currently taking any diabetic medications

How many times per week do you forget to take you diabetes medications?_____

If you take insulin or a non-insulin injectable, please answer the following questions.

What injection sites do you use? (Circle all that apply)

Abdomen Arm Leg Buttocks Other:_____

Do you rotate the injection site with each injection? Yes or No

Where do store unopened insulin/non-Insulin injectable?

_____

Where do you store insulin/non-insulin injectable that are currently in use?

_____

What do you use to deliver insulin?

Vial/Syringe Insulin pen Insulin pump

What is your current Insulin/Non-Insulin Injectable Regimen?

_____
_____
_____

How often do you change syringes, pen needles, or insulin infusion sites?

_____

Where do you dispose of needles/syringes/lancets?

_____

Blood Glucose Monitoring

Are you testing your blood glucose (sugar)?_____

If yes, how often?_____

If yes, what time(s) of the day do you test? (Circle all that apply)

Fasting pre-meal post-meal bedtime overnight as needed

What brand of glucometer do you use?_____

What are your current blood glucose trends: _____mg/dL to _____mg/dL

Do you have a target blood glucose range? Yes or No

If yes, what is it? _____

Do you know your last A1C? Yes or No

If yes, what was the date and result? Date:_____ Result:_____%

Can you tell when your blood sugars are too high? Yes or No

If yes, what symptoms do you get? (Circle all that apply)

Increased Thirst Increased Need to Pass Urine Increase Hunger Sleepy
Blurry Vision Poor Healing Infections Other:_____

Can you tell when your blood sugars are too low? Yes or No

If yes, what symptoms do you get? (Circle all that apply)

Shaky Sweaty Dizzy Sudden Behavior Change Hungry Weak or tired Headache
Nervous or upset Other:_____

Do you have lows that you don't feel? Yes or No

Do you carry something with you to treat lows? Yes or No

What?_____

Do you wear medical ID? Yes or No

Do you have a glucagon emergency kit? Yes or No

Potential Self-Care Risks

Have you ever been diagnosed with depression? Yes or No

If yes, have you ever received care from a counselor or psychologist? Yes or No

For what? _____

When? _____

What was helpful? _____

What was not helpful? _____

Have you been bothered by any of the following in the last 2 weeks: feeling down, depressed, hopeless or had little interest or pleasure in doing things? Yes or No

If yes, how often? (Circle one)

Several days more than half of the time nearly every day only a few days

Do you feel threatened at home, work, or school? Yes or No

If yes, explain: _____

Concerns Specific to Having Diabetes

Please choose whether you agree, disagree or feel neutral with the following statements: (Circle one)

I feel good about my general health. Agree Disagree Neutral

My diabetes interferes with other aspects of my life. Agree Disagree Neutral

I have some control over whether I get diabetes complications. Agree Disagree Neutral

I struggle with making changes in my life to care for my diabetes. Agree Disagree Neutral

My level of stress is high. Agree Disagree Neutral

What do you do to relieve stress?_____

What are your current feelings toward diabetes? (Circle all that apply)

Ok-accepting frustrated angry guilty depressed

Do you have anything that is preventing you from taking care of yourself and your diabetes? (Circle all that apply)

None financial housing utilities access to food difficulty ambulating language barrier inability to do own bathing, cleaning cooking poor vision transportation issues no caregiver

Who helps you the most with your diabetes? (Circle all that apply)

Spouse/Significant other Sibling Child Parent Grandparent Friend No one

Most Important Concerns

What do you feel are your most important concerns regarding your diabetes management?

_____
_____
_____

What would you like to learn during your visit?

_____
_____
_____

Who completed this form?_____

Relationship to pt: _____

Signature:_____ Date:_____ Time:_____