Diabetes Education History Form

Name: _____ Date of Birth: _____ Today's Date: _____

Allergies: ☐ Yes ☐ None known If **Yes**, to what?_____
_____

Medical History: Please check any conditions that you have now or had in the past.

- ☐ No medical conditions
- ☐ Arthritis
- ☐ Gout
- ☐ Bowel problem
- ☐ Cancer
- ☐ Cataracts
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetes in Pregnancy
- ☐ Headaches
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Hospitalized for diabetes
- ☐ Other_____
- ☐ Impotence
- ☐ Kidney disease
- ☐ PCOS
- ☐ Skin ulcer
- ☐ Stroke
- ☐ Thyroid issues

Surgical History: Please check any conditions that you have now or had in the past.

- ☐ No surgeries
- ☐ Abdominal surgery
- ☐ Back surgery
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ Colon surgery
- ☐ Eye surgery
- ☐ Heart surgery
- ☐ Hysterectomy
- ☐ Other_____
- ☐ Kidney transplant
- ☐ Skin biopsy
- ☐ Thoracic surgery
- ☐ Vascular surgery

Family History: Please check the box if your family member has a history of the following conditions.

Relationship	Anemia	Cancer	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Thyroid Disorder
Mother								
Father								
Sister								
Brother								
Son								
Daughter								
Maternal Grandmother								
Maternal Grandfather								
Paternal Grandmother								
Paternal Grandfather								

Alcohol Use: ☐ Yes ☐ Not currently ☐ Never

How many drinks per week: Glasses of wine _____ Cans/Bottles of beer _____ Shots of liquor _____

Sexual Activity: Are you sexually active? ☐ Yes ☐ Not currently ☐ Never

If using birth control, is it hormonal? ☐ Yes ☐ No ☐ None

Comments:_____

Recreational Drug Use: ☐ Yes ☐ Not currently ☐ Never If **Yes**, how many times per week?_____

☐ Anti-anxiety medications ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Methamphetamines

☐ Narcotics ☐ Other _____

Tobacco Use: ☐ Yes ☐ Not currently ☐ Never ☐ Passive smoke exposure

If **Yes**: Start date: _____ Quit date: _____ Packs per day? _____ How many years? _____

Smokeless Tobacco: ☐ Current ☐ Former user ☐ Never used If **Former user**, quit date?_____

Medications & Nutritional Supplements:

☐ Check here if your medication record in Epic is up to date

Pharmacy:_____Phone number: _____

Name	Dose	Route	How often	Date started	What is it for?

DIABETES HISTORY

Why are you coming in for your visit today? _____

What concerns or questions do you have today?_____

General Information:

How do you learn best?

☐ Listening ☐ Looking ☐ Reading ☐ Touching/Doing ☐ Talking/Writing ☐ Thinking/Mathematical

Employment status:

☐ Work full time ☐ Work part time ☐ Stay at home ☐ Looking for work ☐ Retired

Education level:

☐ Completed 8th grade or less ☐ High school graduate ☐ Some college ☐ Associate's degree
☐ Bachelor's degree ☐ Post-graduate degree ☐ Other_____

Barriers to learning:

☐ None ☐ Financial ☐ Written language ☐ Spoken language ☐ Vision ☐ Emotional/Cognitive
☐ Family support ☐ Hearing ☐ Cultural ☐ English as a Second Language ☐ Reading/Numbers
☐ Physical ☐ Use of technology ☐ Other _____

What topics would you like to learn about today?

☐ Healthy eating ☐ Physical activity ☐ Blood glucose monitoring ☐ Low blood glucose treatment
☐ High blood glucose treatment ☐ Long term complications ☐ Coping skills ☐ Diabetes medicines
☐ New technology ☐ Other_____

Relevant Diabetes History:

How long have you had diabetes?

☐ Less than 2 years ☐ 2-5 years ☐ 6-10 years ☐ More than 10 years

When did you last have diabetes education?

☐ Never ☐ Less than 2 years ☐ 2-5 years ☐ 6-10 years ☐ More than 10 years ago

How would you rate your present health status?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any recent changes in your weight?

☐ Recent weight loss ☐ Recent weight gain ☐ No recent weight change
How much? _____ What is your current weight? _____ How tall are you? _____

Have you ever been hospitalized due to diabetes?

☐ In the past year ☐ More than 1 year ago ☐ Never hospitalized for diabetes

Current diabetes symptoms:

☐ None ☐ Excessive thirst ☐ Frequent urination ☐ Unexplained weight loss ☐ Fatigue

☐ Numbness in hands or feet ☐ Blurred vision ☐ Other_____

Blood Glucose Monitoring:

Are you monitoring your blood glucose? ☐ Yes ☐ No If Yes, what meter do you use?_____

How frequently do you test? _____ What are your target blood glucose levels?_____

Low or High Blood Glucose:

Have you had a low blood glucose in the last month? ☐ Yes ☐ No

Can you recognize the symptoms of a low blood glucose? ☐ Yes ☐ No

Comments _____

How do you treat a low blood glucose?

☐ Glucose tabs ☐ Regular juice or soda ☐ Sugar ☐ Candy ☐ Other_____

What are your symptoms of high blood glucose? _____

How do you treat a high blood glucose?

☐ Water ☐ Broth ☐ Exercise ☐ Diabetes medication ☐ Call my provider ☐ Do nothing

Distress Level:

Listed below are problems that people with diabetes may experience. Consider the degree to which each of these may have distressed or bothered you during the past month and circle the answer that best describes how you feel:

1. Feeling overwhelmed by the new diagnosis or demands of living with diabetes?
   Very Somewhat Not at all
2. How important to you is making changes to improving your diabetes care?
   Very Somewhat Not at all
3. How confident are you in your ability to learn about diabetes and make changes to improve your health?
   Very Somewhat Not at all
4. How satisfied are you with how you are managing your diabetes?
   Very Somewhat Not at all

What gets in the way of managing your diabetes?

☐ Stress ☐ Work ☐ Family ☐ Friends ☐ Emotions ☐ Money ☐ Health problems

☐ Lack of time ☐ Lack of knowledge ☐ Nothing ☐ Other_____

Who helps you with your diabetes?

☐ Family ☐ Co-workers ☐ Friends ☐ Health care provider ☐ Support group

☐ No one ☐ Other _____

What methods do you use to manage stress? (Please check all that apply)

☐ Avoid stimulants ☐ Relaxation techniques ☐ Physical activity ☐ Talking to someone
☐ Proper sleep ☐ Learn to say "no" ☐ Keeping a journal ☐ Set realistic expectations
☐ Manage time ☐ Other _____

Meal Planning:

Do you have a meal plan for diabetes management? ☐ Yes ☐ No If **Yes**, what is it?

_____

How well does this meal plan work for you? ☐ Very well ☐ Somewhat ☐ Not at all ☐ Not applicable

Activity:

Do you exercise regularly? ☐ Yes ☐ No If yes, what type of exercise?

☐ Walk ☐ Weights ☐ Gym ☐ Run ☐ Stretches
☐ Stair Stepper ☐ Swim ☐ Yoga ☐ Bike ☐ Aerobics/dance
☐ Other _____

How many times per week do you exercise? _____
How many minutes do you exercise? ☐ Less than 15 ☐ 15-30 ☐ 31-45 ☐ 46-60 ☐ More than 60

Preventive Health:

When did you last have a dilated retinal exam? ☐ Within the 1 year ☐ More than 1 year ago ☐ Never
When did you last see the dentist? ☐ Past 6 months ☐ Past 6-12 months ☐ More than 1 year ago
Do you check your feet daily? ☐ Yes ☐ No
When did you last have a flu shot? _____
When did you last have a pneumonia vaccine? _____

Thank you!

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