Name: _____

Date of Birth: _____ Age: _____

Primary Physician: _____

Specialist: _____

# DIABETES ASSESSMENT AND INTERVIEW

## DIABETES PATIENT PROFILE: *Patient to complete, comment as appropriate*

*EDUCATOR TO COMPLETE*

### HISTORY:

1. When were you diagnosed with Diabetes? Month _____ Year _____
2. Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Other _____
2. What are your most important concerns about managing your diabetes?

   _____

4. Does anyone in your family have diabetes? ☐ NO ☐ YES *who?* _____
5. Do you have a supportive person in your life? ☐ NO ☐ YES *who?* _____

**EDUCATION OBJECTIVES**

- ❑ State that diabetes is a "lifelong" disease
- ❑ Review 4 risk factors for diabetes
- ❑ Identify 2 rationales for diabetes self-management

### MEDICAL HISTORY:

1. Check if you've ever had any of the following conditions:

| | | | | | |
|---|---|---|---|---|---|
| | Stroke | | Cancer _____ | | Sexual Dysfunction/ ED |
| | Heart Attack/MI | | Kidney Disease | | Depression/Mental Illness |
| | High Cholesterol | | Foot Problems | | Cataracts |
| | Heart Bypass/Stents | | Neuropathy | | Glaucoma |
| | Pacer/AICD | | Breathing Problems | | Retinopathy |
| | High Blood Pressure | | Sleep Apnea | | Gestational Diabetes |
| | Circulation Problems | | Stomach Problems | | PCOS |

2. Have you seen a foot doctor? ☐ NO ☐ YES when? (month/yr) _____
3. Do you check your feet daily? ☐ NO ☐ YES
4. When was your last dilated eye exam? (month/year) _____
5. Do you smoke? ☐ NO ☐ YES _____packs per _____day _____ # of years
   a. IF NO: Did you ever smoke? ☐ NO ☐ YES When did you stop? _____

**EDUCATION OBJECTIVES**

- ❑ Discuss 4 long term complications of hyper-glycemia with prevention strategies for each
- ❑ Demonstrate daily foot care regimen
- ❑ State the relationship between diabetes, hypertension, and CVD
- ❑ State importance of routine foot and eye exams.

### MEDICATIONS:

1. Medications for Diabetes: ☐ None ☐ Oral (pills) ☐ Injections (see next page)

   a. If you take pills for diabetes, what do you take, how much and how often?

| Name | Dose | How often? | Times taken? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**EDUCATION OBJECTIVES**

- ❑ State name, dosage, & timing of diabetes pill(s)
- ❑ Discuss how diabetes pill(s) work in the body to help achieve glucose goals

PLEASE COMPLETE OTHER SIDE

**MEDICATIONS continued:**

**b. If you take injections; what type, how much and at what times?**

| Name | Dose | Times taken? | Vial or Pen |
|---|---|---|---|
| | | | ☐ Vial ☐ Pen |
| | | | ☐ Vial ☐ Pen |
| | | | ☐ Vial ☐ Pen |

2. **Who administers your injections?** ☐ **Self** ☐ **Other (who?)** _____
3. **Do you rotate sites?** ☐ **NO** ☐ **YES Where/How?** _____
4. **Where do you store your *UNOPENED* vials or pens?** _____
5. **Where do you store your *OPENED* vials or pens?** _____
6. **Do you use a puncture proof needle disposal container?** ☐ **NO** ☐ **YES**

**EDUCATION OBJECTIVES**

- ❑ Verbalize/Demonstrate insulin injection techniques
- ❑ State correct dosage, action, timing & storage of insulin
- ❑ Review/state proper sharps disposal guidelines

**ACTIVITY/ NUTRITION**

1. **Do you work outside the home?** ☐ **NO** ☐ **YES** ***Work hours:*** _____
2. **Is your job?:** ☐ **N/A** ☐ **Active** ☐ **Inactive**
3. **What type of exercise do you do?** _____

   **How much?** _____ **minutes** _____**days per week**
4. **What do you do for relaxation and enjoyment?** _____
5. **Check all food groups that contain carbohydrates.**

| | | | | | |
|---|---|---|---|---|---|
| | **Milk, Yogurt** | | **Fruits** | | **Vegetables** |
| | **Meat, Poultry & Fish** | | **Bread and grains** | | **Eggs, Cheese** |

**EDUCATION OBJECTIVES**

- ❑ Make a realistic goal and plan for weekly exercise
- ❑ State one activity that can be done for relaxation for 30 minutes per week
- ❑ List four food categories that contain carbohydrates

**MONITORING:**

1. **Do you test your blood sugars at home?** ☐ **NO** ☐ **YES What Meter?** _____
2. **How often?** _____ **Do you use a log book?** ☐ **NO** ☐ **YES**
3. **Where do you get your meter supplies?** ☐ **Pharmacy Plan** ☐ **Medical Equipment Supplier**
4. **What is your most recent HbA1c?** _____ **Date** _____

**EDUCATION OBJECTIVES**

- ❑ Demonstrate SMBG and record keeping
- ❑ State ADA goals for glucose control and testing schedule
- ❑ Discuss 2 rationales for daily SMBG
- ❑ State the relationship between A1c and prevention of long term complications

**HYPOGLYCEMIA**

1. **Have you ever experienced Hypoglycemia (blood sugar less than 70)?** ☐ **NO** ☐ **YES**
2. **Do you know the symptoms of Hypoglycemia?** ☐ **NO** ☐ **YES List one** _____
3. **Do you have any difficulty feeling the symptoms of hypoglycemia?** ☐ **NO** ☐ **YES**
4. **How do you treat low blood sugar?** _____
5. **Do you wear Medical Identification Jewelry?** **NO** ☐ **YES** ☐

**EDUCATION OBJECTIVES**

- ❑ Review signs, symptoms, treatment and prevention plans for hypoglycemic reactions

| **Date:** | **RN Signature:** | **Location(circle):** C M V W |
|---|---|---|