

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:**

- When were you diagnosed with Diabetes? Month \_\_\_\_\_ Year \_\_\_\_\_
- Type of Diabetes:  Type 1  Type 2  Other \_\_\_\_\_
- What are your most important concerns about managing your diabetes?  
 \_\_\_\_\_
- Does anyone in your family have diabetes?  NO  YES *who?* \_\_\_\_\_
- 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:**

- 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

- Have you seen a foot doctor?  NO  YES when? (month/yr) \_\_\_\_\_
- Do you check your feet daily?  NO  YES
- When was your last dilated eye exam? (month/year) \_\_\_\_\_
- Do you smoke?  NO  YES \_\_\_\_\_ packs per \_\_\_\_\_ day \_\_\_\_\_ # of years
  - IF NO: Did you ever smoke?  NO  YES When did you stop? \_\_\_\_\_

**EDUCATION OBJECTIVES**

- Discuss 4 long term complications of hyperglycemia 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:**

- Medications for Diabetes:  None  Oral (pills)  Injections (see next page)
  - 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

<b>MEDICATIONS continued:</b>		<b>EDUCATION OBJECTIVES</b>																	
<p>b. If you take injections; what type, how much and at what times?</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Name</th> <th style="width:15%;">Dose</th> <th style="width:15%;">Times taken?</th> <th style="width:37%;">Vial or Pen</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> Vial   <input type="checkbox"/> Pen</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> Vial   <input type="checkbox"/> Pen</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td><input type="checkbox"/> Vial   <input type="checkbox"/> Pen</td> </tr> </tbody> </table> <p>2. Who administers your injections?   <input type="checkbox"/> Self   <input type="checkbox"/> Other (who?) _____</p> <p>3. Do you rotate sites?   <input type="checkbox"/> NO   <input type="checkbox"/> YES   Where/How? _____</p> <p>4. Where do you store your <i>UNOPENED</i> vials or pens? _____</p> <p>5. Where do you store your <i>OPENED</i> vials or pens? _____</p> <p>6. Do you use a puncture proof needle disposal container?   <input type="checkbox"/> NO   <input type="checkbox"/> YES</p>		Name	Dose	Times taken?	Vial or Pen				<input type="checkbox"/> Vial <input type="checkbox"/> Pen				<input type="checkbox"/> Vial <input type="checkbox"/> Pen				<input type="checkbox"/> Vial <input type="checkbox"/> Pen	<p><input type="checkbox"/> Verbalize/Demonstrate insulin injection techniques</p> <p><input type="checkbox"/> State correct dosage, action, timing &amp; storage of insulin</p> <p><input type="checkbox"/> Review/state proper sharps disposal guidelines</p>	
Name	Dose	Times taken?	Vial or Pen																
			<input type="checkbox"/> Vial <input type="checkbox"/> Pen																
			<input type="checkbox"/> Vial <input type="checkbox"/> Pen																
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<b>ACTIVITY/ NUTRITION</b>		<b>EDUCATION OBJECTIVES</b>																	
<p>1. Do you work outside the home?   <input type="checkbox"/> NO   <input type="checkbox"/> YES   <i>Work hours:</i> _____</p> <p>2. Is your job?:   <input type="checkbox"/> N/A   <input type="checkbox"/> Active   <input type="checkbox"/> Inactive</p> <p>3. What type of exercise do you do? _____</p> <p style="padding-left: 40px;">How much?   _____ minutes   _____ days per week</p> <p>4. What do you do for relaxation and enjoyment? _____</p> <p>5. Check all food groups that contain carbohydrates.</p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="width:25%;">Milk, Yogurt</td> <td style="width:25%;">Fruits</td> <td style="width:25%;">Vegetables</td> <td style="width:25%;"></td> </tr> <tr> <td>Meat, Poultry &amp; Fish</td> <td>Bread and grains</td> <td>Eggs, Cheese</td> <td></td> </tr> </table>		Milk, Yogurt	Fruits	Vegetables		Meat, Poultry & Fish	Bread and grains	Eggs, Cheese		<p><input type="checkbox"/> Make a realistic goal and plan for weekly exercise</p> <p><input type="checkbox"/> State one activity that can be done for relaxation for 30 minutes per week</p> <p><input type="checkbox"/> List four food categories that contain carbohydrates</p>									
Milk, Yogurt	Fruits	Vegetables																	
Meat, Poultry & Fish	Bread and grains	Eggs, Cheese																	
<b>MONITORING:</b>		<b>EDUCATION OBJECTIVES</b>																	
<p>1. Do you test your blood sugars at home?   <input type="checkbox"/> NO   <input type="checkbox"/> YES   <i>What Meter?</i> _____</p> <p>2. How often? _____   <i>Do you use a log book?</i>   <input type="checkbox"/> NO   <input type="checkbox"/> YES</p> <p>3. Where do you get your meter supplies?   <input type="checkbox"/> Pharmacy Plan   <input type="checkbox"/> Medical Equipment Supplier</p> <p>4. What is your most recent HbA1c? _____   <i>Date</i> _____</p>		<p><input type="checkbox"/> Demonstrate SMBG and record keeping</p> <p><input type="checkbox"/> State ADA goals for glucose control and testing schedule</p> <p><input type="checkbox"/> Discuss 2 rationales for daily SMBG</p> <p><input type="checkbox"/> State the relationship between A1c and prevention of long term complications</p>																	
<b>HYPOGLYCEMIA</b>		<b>EDUCATION OBJECTIVES</b>																	
<p>1. Have you ever experienced Hypoglycemia (blood sugar less than 70)?   <input type="checkbox"/> NO   <input type="checkbox"/> YES</p> <p>2. Do you know the symptoms of Hypoglycemia?   <input type="checkbox"/> NO   <input type="checkbox"/> YES   <i>List one</i> _____</p> <p>3. Do you have any difficulty feeling the symptoms of hypoglycemia?   <input type="checkbox"/> NO   <input type="checkbox"/> YES</p> <p>4. How do you treat low blood sugar? _____</p> <p>5. Do you wear Medical Identification Jewelry?   NO <input type="checkbox"/>   YES <input type="checkbox"/></p>		<p><input type="checkbox"/> Review signs, symptoms, treatment and prevention plans for hypoglycemic reactions</p>																	
Date:	RN Signature:	Location(circle):   C   M   V   W																	