Name: _____

Date of Birth: _____ **Age:** _____

Primary Physician: _____

Referring provider: _____

DIABETES & NUTRTION ASSESSMENT

What is the reason for your appointment? _____

What questions or concerns do you have about diabetes? _____

What do you expect from your appointment today? _____

What type of diabetes? (Please circle one of the following)

Type 1 Type 2 Pre- diabetes LADA(Type 1 ½) Gestational Other_____

Is this a new diagnosis? YES NO Age when were you were diagnosed? _____

Have you ever had diabetes education before? NO YES Where/When? _____

FOR PREGNANCY ONLY OTHERWISE SKIP TO NEXT SECTION (Fill in the blanks)

LMP_____ **How many weeks** _____ **Due date** _____

Pre-pregnancy weight? _____ **If expecting more than one? How many**_____

Total pregnancies (including this one) _____ **Total children** _____ **Total miscarriages**_____ **Other**_____

Any previous pregnancy complications? No Yes explain_____

RISK FACTORS (circle all that apply)

Does/Did anyone in your family have diabetes? NO YES - Grandparent Mom Dad Sibling Aunt/Uncle

Ethnicity? African American Native American Hispanic Asian Middle Eastern Caucasian Other

Do you exercise? NO YES Type: Cardio Strength training Stretching Yoga

Days/week_____ **Total minutes/week**_____

What is your smoking history? Never Former smoker Current smoker

What is your smokeless tobacco (ST) history? Never Former ST smoker Current ST smoker

How would you describe your current use of alcohol? Never Rarely Monthly Weekly Daily

Have you ever had Gestational diabetes? YES NO N/A

Has anyone told you that you snore loudly? YES NO

Do you get 7 or more hours of sleep per day? YES NO

Do you have any problems falling or staying asleep? YES NO

NUTRITION ASSESSMENT (circle & fill in the blanks)

Height _____ Weight_____ Any weight changes in the last 3-6 months? NO Gain_____ lbs. Loss_____ lbs.

Have you made changes in diet since diagnosis? Explain _____

Have you had weight loss surgery? NO YES When_____ Type_____

Who cooks at home? Self Other_____ Who grocery shops at home? Self Other_____

How often do you dine out? (includes all meals) _____ times a week month year

Do you look at food labels regularly? NO YES

Do you have any food allergies? NO YES _____

Are there foods you avoid? NO YES_____

Are you Vegetarian? NO YES Type_____

Which of the following foods are considered carbohydrates (foods that turn to blood sugar)? (circle all that apply)

Milk yogurt cheese butter fruit vegetables cereal bread rice meat eggs fish nuts

What meals do you eat daily? Breakfast Lunch Dinner

What times do you eat snacks daily? Morning Afternoon Evening

INJECTABLE MEDICATIONS (circle & fill in the blanks) N/A

What type do you take? Pre-filled Pen Syringe and Vial Insulin Pump _____

Who administers them? Self Other_____

What injections sites do you use? Abdomen Thigh Arm Buttocks Other_____

Do you change injections site with each injection? No Yes

Where do you store unused/Unopened injectable medication? Refrigerator Room temperature

Where do you store In-use/Opened injectable medication? Refrigerator Room temperature

Where do you put used needles and lancets? _____

HYPOGLYCEMIA (Circle & fill in the blanks)

Have you ever had a blood sugar below 70-80(hypoglycemia)? No Yes

If Yes; What is the blood sugar level when you first notice it? _____

What symptoms do you have? Shaky Sweaty Hungry Weak Nervous/Anxious Confused

Difficulty speaking Sleepy Passing out Violent

Have you noticed any patterns of low blood sugar? No Yes explain_____

How do you treat low blood sugar? _____

HYPERGLYCEMIA (Circle & fill in the blanks)

Do you ever have high blood sugar(hyperglycemia)? No Yes

What are your symptoms of high blood sugar? Thirsty Hungry Tired Increased urination

Numbness/pain/tingling in feet or hands Dry mouth

Have you ever been hospitalized for High blood sugar? No Yes

MONITORING/SELF CARE (Circle & fill in the blanks)

Do you use a home glucose monitor? No Yes name_____

Do you wear a CGM(continuous glucose monitor) No Yes name_____

If applicable—Do you test urine for Ketones? No Yes

Do you wear medical alert ID No Yes

Do you or someone else look at the tops & bottoms of your feet daily? No Yes

Do you get a yearly comprehensive foot exam? No Yes--- Last appt: _____

Do you get a yearly dilated eye exam? No Yes – last appt: _____

Do you get your teeth cleaned every 6 months? No Yes

Do you get a yearly flu shot? No Yes

Have you ever had a Pneumonia Vaccine? No Yes

Employment? N/A Occupation? _____ Shift? Days Evenings Nights Rotate

Activity at work? Active all the time Active some of the time Not active

Years of school completed? _____

Marital Status? Single Widowed Separated Married Divorced

If female, do you have any plans for pregnancy? NA No Yes

How many people are in your household? _____

Do you have an emotional support person/persons? No Yes

Do you have any current Stressors? No Yes _____

Fill out only if you do not have a Virtua Medical Group physician

Medical History Please check if you have been treated for any of the following							
	Allergies		COPD		High Blood pressure		Thyroid disease
	Anemia		Depression		Irritable bowel disease		
	Anxiety		Eating Disorder		Kidney disease		
	Arthritis		Gallbladder disease		Liver disease		**Surgical History**
	Asthma		GERD/Ulcer		Neuropathy		Amputation
	Atrial Fibrillation		Glaucoma		Osteoporosis		Bariatric Surgery
	Cancer _____		Headaches/Migraines		Retinopathy		Bowel Surgery
	Cardiac Arrhythmia		High Cholesterol		Seizure disorder		Heart Bypass
	Cataracts		Heart Valve disorder		Sleep Apnea		Laser eye surgery
	Clotting disorder		Heart Attack/MI		Stroke		Cardiac Stents

Please write all medications here or provide a separate list.

Pills

Name	**Dose**	**How often?**	**Time taken?**

Vitamins/Herbal Supplements

Name	**Dose**	**How often?**	**Time taken?**

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

Name	**Dose**	**Time taken?**	**Vial or Pen**
			☐ **Vial** ☐ **Pen**
			☐ **Vial** ☐ **Pen**
			☐ **Vial** ☐ **Pen**